CHAPTER - 2

LITERATURE REVIEW

2.1 Introduction:

The World Health Organization (WHO) as “the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” has defined health care. Health care remains one of the most important human endeavors to improve the quality of life. It also provides a comprehensive definition of a health care system as one of that “…encompasses all the activities whose primary purpose is to promote, restore or maintain health….and include(s) patients and their families, health care workers and caregivers within organizations and in the community and the health policy environment in which all health related activities occur.”

The main objective of any healthcare system is to facilitate the achievement of optimal level of health to the community through the delivery of services of appropriate quality and quantity. One another objective of health reform worldwide is to hold healthcare accountable for its resource use and the way healthcare services are delivered. This relates not only to the overall health of individuals and communities but to the quality of the healthcare experience (Reinhardt, 1998). The structure of the health care system in India is complex and includes various types of providers. These providers practice in different systems of medicines and facilities. The providers and facilities in India can be broadly classified by using three dimensions: ownership styles (public, private not –for profit, private for-profit and private informal); systems of medicines (allopathic, homeopathic and traditional); and types of facilities (hospitals, dispensaries and clinics). These dimensions are interdependent and overlapping (Bhat, 1993).

Using the ownership criterion, the health care system can be divides into four board sectors:

- The public sector, including government-run hospitals, dispensaries, clinics, primary health care centers and sub centers and paramedics.

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• The private not-for-profit sector, including voluntary health programs charitable institutions, missions, churches and trusts
• The organized private for-profit sectors, including general practitioners (having at least a bachelor’s degree or equivalents in medicine), private hospitals and dispensaries (popularly known as nursing homes), registered medical practitioners and other licensed practitioners.
• The private informal sector, including practitioners without formal qualifications (such as faith healers, herbalists, tantriks, hakims, and vaidyas).

Increasing the availability, accessibility and awareness about the services and technological advances for the management of health problems, raising expectations of the people, and the ever-increasing cost of healthcare are some of the challenges that the healthcare systems have to cope up with. The development of the private health care sector is due to a number of interacting factors. These factors include the growth of household incomes, the inadequacies of the public health sector, and the effects of various government policies on the operation of different health care markets (Alejandro Herrin, 1997). The private health sector plays an important role in India’s health care delivery system. Through a wide network of health care facilities, this sector caters to the needs of both urban and rural populations and has expanded widely to meet increasing demands.

This increasing importance has raised requirements for health care marketing. The American Marketing Association offers, “Marketing is an organizational function and a set of processes for creating, communicating and delivering value to customers and for managing customer relationship in ways that benefits the organization and its stakeholders” (Kotler Philip, Sholawitz Joel et al, 2008).

The level of competition has increased in health care sector. Patients’ satisfaction is emphasized highly in competitive market. Patient satisfaction with medical care is a multidimensional concept, with dimension that corresponds to the major characteristics of providers and services. Patient satisfaction with health care services

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4 Kotler Philip, Sholawitz Joel and Steven J. Robort, 2008 titled “Strategic organisations Building a customer driven Health system published by Jobssey-Bass, A Wiley Imprint, p.5
is considered to be of paramount importance with respect to quality improvement programs from the patients’ perspective, total quality management, and the expected outcome of care. Within the health care industry, patient satisfaction has emerged as an important component and measure of the quality of care. Consumer satisfaction appears to be a major device in order to take critical decisions in the health care services \(^5\). Therefore, service providers, as a matter of fact, take the satisfaction of customers into account as a main goal of the strategies of their firms \(^6\). Patient satisfaction plays an important role in continuity of service utilization. Satisfied patients are more likely to adhere to doctors’ recommendations and medical suggestions. Besides, dissatisfied patients do not use that health care services. The fast developing health care industry, hospitals like their counterparts, have to deal with several service product characteristics such as intangibility, heterogeneity and perishability more over high risk exist for the private hospitals offering their services in a competitive environment dealing with human health, which involves sensitive decision.

2.2 Patient Satisfaction:

Notionally, consumer surveys or patient feedbacks can be used for assessment of individual clinician, trust, organisation or region and analysed to compare it with its/their own past performances, similar surveys at different hospitals, national average or benchmarked performances. These can help in improving insight and help to learn from own or others experiences. Likewise these can be useful tool for policymakers, researchers, and for managers to know more about their services. The outcomes of the consumer surveys can be used by the governing or regulatory bodies like Health Care Commission to measure performance.

RituNarang (2010)\(^7\) applied 20-item scale and distributed to 500 users of health care centers comprising a tertiary health center, a state medical university and two missionary hospitals in Lucknow, India. The scale was found to be reliable to a great extent with an overall Cronbach alpha value of 0.74. “Health personnel


and practices” and “health care delivery” were found to be statistically significant in affecting the perception. Respondents were relatively less positive on items related to “access to services” and “adequacy of doctors for women”. The tertiary health center was rated poorer than the medical university and missionary hospitals. Policy makers needed to consider the requirements and opinions of patients to effect substantial change and significant improvement in the quality of their health care services for better and increased utilization of their services. This tool may be applied for qualitative assessment of the services of health care programmes as well as health care centers of India.

2.2.1 Consumer survey as an effective tool to improve:

Patient satisfaction had been extensively studied and considerable effort had gone into developing survey instruments to measure it. However, most reviews have been critical of its use, since there was rarely any theoretical or conceptual development of the patient satisfaction concept. The construct had little standardization, low reliability and uncertain validity. It continued to be used interchangeably with, and as a proxy for, perceived service quality, which was a conceptually different and superior construct.

Anjali Patwardhan (2009) tried to find effectiveness of consumer surveys as valuable to implement service improvement tool in health services. In the recent climate of consumerism and consumer focused care, health and social care needs to be more responsive than ever before. The consumer needs and preferences can be elicited by customaries and specific consumer surveys. Most researchers now go for consumer experience surveys rather than just satisfaction surveys because of their clear superiority in identifying the specific opportunities for improvement and the ease of translating the outcome information from these surveys in to the strategic planning for improvement.

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2.2.2 Factors affecting Patients’ satisfaction:

Healthcare is a high involvement service as it concerns the person’s health and well being. Customer satisfaction and loyalty are such a strong and “value-laden” notion that it is usually applied only to family and friends. Patient satisfaction has always and will be a fundamental requirement for clinical and financial success of any organization providing health care, regardless of specialty. Nesreen A. Alaloola (2008) conducted research survey to find Patient satisfaction in a Riyadh Tertiary Care Centre. Patients were significantly satisfied with treatment room cleanliness (90 percent). They were significantly dissatisfied, on the other hand, with the interpreter’s failure to introduce him/her self (57.6 percent). They were significantly satisfied with the time he/she spent with doctors (90.1 percent) and the way they were treated with respect and dignity (74.8 percent). Also, patients were significantly satisfied with emergency care staff allowing relatives to accompany patients undergoing treatment (60.9 percent). Discharge medication and related information was well rated (67.1 percent) and post discharge care information generally (56.4 percent). There was significant satisfaction with pharmacists treating patients with respect and dignity (79.4 percent), explaining how to use their medications (78.1 percent) and that all prescribed medications were available from the pharmacy (60.7 percent). Finally, patients were significantly dissatisfied with emergency care staff information (52.7 percent), while they were significantly satisfied with the military police being available to provide directions if needed (77.6 percent), staff respecting the Saudi culture (82.8 percent) and communicating ease (82.1 percent).

Kenneth E. Covinsky, and Gary E. Rosenthal, et al. (1999) interviewed patients at admission and discharge to obtain two measures of health status. At discharge, they also administered a 5-item patient satisfaction questionnaire. They assessed the relation between changes in health status and patient satisfaction. In two sets of analyses, that controlled for either admission or discharge health status. They found

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that Patients with similar discharge health status had similar satisfaction regardless of whether that discharge health status represents stable health, improvement, or a decline in health status. The previously described positive association between patient satisfaction and health status more likely represents a tendency of healthier patients to report greater satisfaction with health care. They suggested that changes in health status and patient satisfaction were measuring different domains of hospital outcomes and quality.

Accurate diagnosis and treatment are no longer enough; patients need performance in all services they receive. Performance makes consumers return to the same provider and spread more favorable “word of mouth” recommendation. Moreover, human beings live as members of groups that share common values and norms and interact according to specific rules and laws, which shape several human reactions.

Amira Elleuch (2008) tried to measure patient satisfaction in Japan. Japanese healthcare service quality was evaluated using its process characteristics (patient-provider interaction) and physical attributes (settings and appearance). Process quality attributes found experience patient satisfaction. Satisfaction in turn predicts patient intentional behavior (to return and to recommend). Japanese society cultural specificity seems to be an interesting background to understand Japanese evaluation when patients assess health service quality. In accordance with their culture’s specificities, Japanese outpatients focus on delivery processes – characterized by service speed, quality of interaction with staff and the setting’s appearance when assessing health care service quality. In contrast with individualist cultures (USA and Europe), Japanese hate specific attention and individualized staff behaviors considering that physicians or nurses should deal equally with all the patients.

Patients’ satisfaction largely depends on how nicely services are being delivered. Nurses are playing very important role and nurses are the largest groups among health care professionals and are legally liable and morally responsible for their care, thus their perspective on quality of nursing care is important. Mansoureh Z. Tafreshi,

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Mehrnoosh Pazargadi and Zhila Abed Saeedi (2007)\textsuperscript{12} have made an attempt to find similarities and differences between nursing experts’ and clinical nurses’ perspectives on quality and patient satisfaction. Findings revealed that in nurses’ perspectives on quality definition two important aspects have been mostly considered: “standard of care” and “patient satisfaction”. Moreover participant groups have emphasized the benefits of collaborative work in health care (teamwork). Further in this study, organizational and socio-cultural roles in delivering quality nursing care have been mentioned such as staffing, budget, leadership, and social perspectives about nursing as a highly educated profession.

Koichiro Otani& Fort Wayne (2009)\textsuperscript{13} conducted the study to find out what influenced adult patients to rate their overall experience as "excellent." The data collected from one major academic hospital and four community hospitals. After conducting a multiple logistic regression analysis, certain attributes were shown to be more likely than others to influence patients to rate their experiences as excellent. The study revealed that staff care was the most influential attribute, followed by nursing care. These two attributes were distinctively stronger drivers of overall satisfaction than the other attributes studied (i.e., physician care, admission process, room, and food). Staff care and nursing care were found under the control of healthcare managers.

Hospital food services are an important component in the healthcare management of patients. The provision of patient meals should be regarded as a component of hospital treatment as the nutrients provided can promote recovery, especially if patients have no other options for getting food while hospitalized. Measuring patient satisfaction toward hospital food services is one tool used in research to improve food quality and catering services (Capra et al., 2005)\textsuperscript{14}. Rosita Jamaluddin, Nurul Mansoureh Z. Tafreshi, MehrnooshPazargadi and Zhila Abed Saeedi (2007) Nurses’ perspectives on quality of nursing care: a qualitative study in Iran, International Journal of Health CareQuality AssuranceVol. 20 No. 4, 2007 pp. 320-328.


Aqmaliza AbdManan (2010) found the majority of the patients were satisfied with the food service in Malaysia. Energy (kcal) and protein intakes from hospital food were higher than that of outside food. However, most patients did not obtain their full energy and protein requirements from the hospital food provided.

Satisfying patients' needs is found the first step toward having loyal patients, so hospitals that strive to ensure their patients were completely satisfied and more likely to prosper. Nesreen A. Alaloola (2008) conducted research survey to find Patient satisfaction in a Riyadh Tertiary Care Centre. There was a significant satisfaction with room comfort, room temperature, room call button system, room cleanliness and respectful staff. Patients were significantly dissatisfied with phlebotomists not introducing themselves, not explaining procedures and physicians not introducing themselves.

Satisfaction determinants range from structurally based ones such as the type of health care delivery system, to physician characteristics, including interactional style and the physician’s age. Patients are difficult to satisfy, inconsolable and personally challenging, no matter how comprehensive, efficient and expert neither care, nor how polished the physician’s interpersonal skills. Patient satisfaction has been widely studied. Brian A. Costello, Thomas G. McLeod and G. Richard Locke III (2008) conducted a research survey to find Pessimism and hostility scores as predictors of patient satisfaction ratings by medical out-patients patients’ satisfaction. Among the hostile patients, 57 percent rated their overall care by physicians as excellent, while 66 percent of the least hostile patients rated it as excellent.

Dennish J Scotti and Joel Harmon (2009) assessed the importance of customer-contact intensity at the service encounter level as a determinant of service quality assessments. It showed that performance-driven human resources practices play an

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important role as determinants of employee customer orientation and service capability in both high-contact (outpatient healthcare) and low-contact (benefits claim processing) human service contexts. However, there existed significant differences across service delivery settings in the customer orientation and the similarity between employee and customer perceptions of service quality, depending on the intensity of customer contact. In both contexts, it was found that managerial attention to high-performance work systems and customer-orientation has the potential to favorably impact perceptions of service quality, amplify consumer satisfaction, and enhance operational efficiency.

Michael Schroeter & Igor Savitsky (2010)\textsuperscript{19} tried to investigate the implementation of a novel organizational structure in a specialized hospital department. The key issue was to optimize the efficiency of the process “hospital treatment” in a patient-oriented approach. A new organizational concept, i.e. the Cologne Consultant Concept (CCC), was developed by and implemented at the Department of Neurology, Cologne University Hospital in August 2007. The outcome of this reorganization was evaluated via a number of critical performance parameters (effects on daily routines and performance data, feedback from quality control and house officers). Furthermore, the strengths and weaknesses of this novel system were compared to the traditional ward-based system in Germany, the Anglo-American consultant model and care provided by sub-specialized teams. The reorganization of the healthcare services by the CCC provided flexible medical care for inpatients. The independent assignment of patients to a ward, and a team of physicians offered incentives for case-oriented and efficient medical treatment. Furthermore, beneficial effects on the department’s overall performance compared to the traditional ward-based system were observed. The CCC constituted a valuable new organizational structure that can provide medical care in any specialized hospital department.

In any hospital emergency department is playing very important role. Emergency departments (EDs) are an important hub in our health care system. They handle acute illnesses and injuries, are an important gateway to admission to hospitals and also

\textsuperscript{19} Michael Schroeter & Igor Savitsky (2010); A novel organizational structure to provide medical care in specialized hospital departments: The Cologne Consultant Concept, Leadership in Health Services Vol. 23 No. 4, 2010 pp. 320-333
provide medical care when a patient’s regular physician is unavailable. Keith A. Willoughby & Benjamin T.B. Chan (2010) made study to determine the wait time and service time for various emergency department (ED) patient care processes and to apply the science of plan-do-study-act (PDSA) cycles to improve patient flow. The paper used direct observation to collect patient-flow data on 1,728 patients at multiple ED sites in Saskatchewan, Canada. It calculated wait times and services associated with important care processes and then tested, measured and implemented ideas to reduce wait time. The study discovered on an average, patients spend nearly five hours in the ED with about one-half of the visit devoted to waiting for the next required service to take place. Waiting for an inpatient bed, specialist consultation or physician reassessment comprised relatively long wait times. Through the use of visual reminders and standard process worksheets, quality improvement teams were able to achieve large reductions in physician reassessment waiting time. These improvements required minimal materials cost and no additional staff.

Marie Boltz, Elizabeth Capezuti and Nina Shabbat (2010) tried to define the core components of a system-wide, acute care program designed to meet the needs of older adults. Concept mapping methodology (multidimensional scaling and cluster analysis) was used to obtain data describing the core components of a geriatric acute care model. The input of 306 “stakeholders” (clinicians, administrators, consumers, educators, and researchers) was obtained through a World Wide Web interface, supplemented with consumer interviews. The findings yielded eight clusters describing components of a geriatric acute care program: guiding principles, leadership, organizational structures, physical environment, patient- and family-centered approaches, aging-sensitive practices, geriatric staff competence, and interdisciplinary resources and processes.

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20Keith A. Willoughby & Benjamin T.B. Chan (2010), Achieving wait time reduction in the emergency department; Leadership in Health Services Vol. 23 No. 4, 2010 pp. 304-319.

21Marie Boltz, Elizabeth Capezuti and Nina Shabbat (2010); Building a framework for a geriatric acute care model; Leadership in Health Services Vol. 23 No. 4, 2010 pp. 334-360.
Johan Hellings, Ward Schrooten and Niek Klazinga (2007) measured patient safety culture in five Belgian general hospitals. Safety culture played an important role in the approach towards greater patient safety in hospitals. The dimensional positive scores were found to be low to average in all the hospitals. The lowest scores were “hospital management support for patient safety”, “non-punitive response to error”, “hospital transfers and transitions”, “staffing”, and “teamwork across hospital units”. The dimension “teamwork within hospital units” generated the highest score. Although the same dimensions were considered problematic in the different hospitals, important variations between the five hospitals were observed.

Seetharaman Hariharan, Prasanta Kumar Dey (2010) introduced a quality management framework by combining cause and effect diagram and logical framework. An intensive care unit was identified for the study. They found that patients improved infrastructure, state-of-the-art equipment, well maintained facilities, IT-based communication, motivated doctors, nurses and support staff, improved patient care and improved drug availability were considered the main project outputs for improving performance. The proposed framework was used as a continuous quality improvement tool, providing a planning, implementing, monitoring and evaluating framework for the quality improvement measures on a sustainable basis.

Peter Hensen, Meinhard Schiller, Dieter Metze and Thomas Luger (2008) evaluated the perception of hospital services by referring physicians and clinicians for quality improvement. Referring physicians in private practice and hospital clinicians at a large dermatology academic department providing inpatient and outpatient services at secondary and tertiary care levels were surveyed to determine their perceptions of service quality. A comparative questionnaire survey was established to identify improvement areas and factors that drove referral rates using descriptive and inferential statistics. Referring physicians’ (n = 53) and

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clinicians’ (n = 22) survey results concordantly revealed that timely and significant information about hospital stay as well as accessibility to hospital staff were major points for improvement. Significant differences between both samples were found with respect to inpatient services and patient commendation. Clinicians tended to rate their services and offerings higher than referring physicians (p < 0.019). Geographic range was correlated with the frequency of patient commendation (p < 0.005) and the perception of friendliness (p < 0.039). The number of referred patients was correlated with medical reports’ informational value (p < 0.042).

Nurses heavily influence patient care quality and safety. **Ari Mawachofi and Stephen L. Walston (2011)** attempted to find factors affecting nurses’ perceptions of patient safety. This paper aimed to examine socioeconomic and organizational/system factors affecting patient safety and quality perceptions. They found that improved patient safety and the likelihood that nurses use their own facility include: fewer visible errors; ability to communicate suggestions; information technology support and training; and a confidential error reporting system. Furthermore, nursing in these hospitals was dominated by foreign nationals. The high positive patient safety perceptions may be influenced by either individual or peer biases.

**Abdul MajeedAlhashem, HabibAlquraini and Rafiquil I. Chowdhury(2011)** measured the quality of health care services and patient satisfaction as one of the most important indicators. The study aimed to identify factors affecting patient’s satisfaction at primary health care clinics. The data was collected during January 2007 and May 2007 through a randomly-distributed questionnaire. The questionnaires were distributed in primary healthcare clinics that represent all health care regions in Kuwait. A total of 426 completed questionnaires, out of 500, were returned resulting in a response rate of 85.2 percent. The majority (87 percent) of the patients responded that the time for communication between physician and patient was not enough.


Seventy-nine-percent of the surveyed patients said they would go to the emergency room of the hospital in future if needed instead of going to the primary care clinic. Regarding the quality of the communication relationship between physician and patients most of the patients responded negatively.

**Masood A. Badri and SamaaAttia (2009)** discussed goodness-of-fit statistics supported the healthcare quality-patient status-satisfaction model. Their results sent an important message to hospital managers, confirming that healthcare quality in terms of reliability (including competence, knowledge and trust), professionalism and courtesy, empathy and tangibles were crucial when it comes to evaluating services.

Complaints about the provision of health care have increased as consumers’ expectations of care and awareness of their rights have grown (**Anderson et al., 2001; Chavan et al., 2007**). Health professionals and/or health care organisations may react to complaints with fear and defensiveness (**Anderson et al., 2001**). **Julianne Parry and UdulHewage (2009)** conducted a research survey in Australia to know the complaints resolution. And found that Three main themes. These themes were labelled: “communication”, “wait times” and “clinical”. The complaints were readily identified as falling into three main themes. These were: complaints about communication, complaints about wait times and complaints labelled as “clinical” as they related to concerns about the care provided to the patient or their relative.

Satisfaction with quality parameters like service proximity, doctor availability, waiting time, etc., can be used as a performance goal to evaluate healthcare organisations. Citizen satisfaction is the most important parameter. **Sandip Anand**

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29 Ibid 8
carried out the follow-up survey in Tamil Nadu, Maharashtra, Bihar and Jharkhand. Dimensions include: service proximity, doctor availability, waiting time, medicines, facility cleanliness, dignified treatment, privacy, service affordability and treatment effectiveness. Findings indicated that doctor availability, waiting time, cleanliness, privacy and affordability at private health facilities enhance the probability that a health facility will be used for any reproductive health purpose. Their findings indicated that doctor availability, waiting time, cleanliness, privacy and affordability enhance private reproductive health service use at the combined four state level. At the combined states, medicine availability and treatment effectiveness at public health facilities enhances use. It appeared from their findings that service quality norms were not properly established in any Indian public or private systems. Therefore, to improve health service quality, hospitals need to emphasise holistic care. At the combined states level, medicine availability and treatment effectiveness at public health facilities enhances service use.

2.2.3. Patients’ loyalty:

Patient satisfaction affects propensity to return, i.e. loyalty. Based on the existing evidence that the patient satisfaction was found an unpredictable construct, a focus entirely on perceived service quality, as the definitive construct, was justified; and given the extremely high intensity nature of the service. Satisfaction’s impact on hospital choice is particularly important. Research shows a link between patient satisfaction and healthcare quality.

Reichheld developed a model for connecting customer satisfaction to quality, improvement, customer loyalty and retention. He suggested that a single question can explain 90 per cent of customer satisfaction variance (Reichheld, 2006). This question, which he terms “the ultimate question”, is: “On a scale from 0-10, how likely are you to recommend a product or service to a colleague, family member, or friend?” Thus, the most natural thing for a customer to do if he or she

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loves doing business with a particular provider is recommend that provider to someone he/she cares about (Reichheld, 2006)33.

Patient satisfaction actually predicts provider choice suggests a pathway through which individuals naturally gravitate toward higher-quality care, despite the difficulties inherent in evaluating service quality. Satisfied patients are also more likely to adhere to recommended treatment. Daniel P. Kessler and Deirdre Mylod (2011)34 aimed to investigate the same. The results showed a statistically significant link between patient satisfaction and loyalty. This result persists, even holding constant hospital characteristics and process-based quality measures likely to be highly salient to satisfaction. Although this result was statistically significant, it was relatively small in magnitude.

Helena Vinagre and Jose´ Neves (2010)35 have found the more a patient feels interested and joyful, the better his appreciation of justice in doctor-patient relationship and the healthcare centre processes.

Delivering best quality of services is important at the same time this should have been done more effectively and efficiently. J. Dummer (2007)36 found that the task of defining the way in which health care could be most efficiently and effectively delivered was the concern of all health care staff. Management also had the responsibility of ensuring the consistency and coherence of the many different activities that contributed to the aim of good health care.

Amy Lodge, David Bamford (2007)37 had tried to measure health service improvement through diagnostic waiting list management. The results were recognised as being beneficial to all parties, especially the patients. Staff recognised the need for change; the process transformation was actually welcomed. Patient

37 Amy Lodge, David Bamford (2007), Health service improvement through diagnostic waiting list management; Leadership in Health Services Vol. 20 No. 4, 2007 pp. 254-265.
waiting times reduced from 26 to 13 weeks. Fast-track “query cancer” service for out-patients now within ten days; the majority of in-patients receive imaging within 72 hours. Ultimately, patients were diagnosed faster and treatment commences earlier.

A high-involvement approach to the work environment of healthcare employees may lead to exceptional service quality, satisfied patients, and ultimately to loyal customers. **Dennis J. Scotti, Alfred E. Driscoll (2007)** said healthcare managers must deliver high-quality patient services that generate highly satisfied and loyal customers. In this article, researchers had investigated how specifically, the chain of events through which high-performance work systems (HPWS) and customer orientation influence employee and customer perceptions of service quality and patient satisfaction. They presented a conceptual model for linking work environment to customer satisfaction and test this model using structural equations modelling. The results suggested that (1) HPWS was linked to employee perceptions of their ability to deliver high-quality customer service, both directly and through their perceptions of customer orientation; (2) employee perceptions of customer service were linked to customer perceptions of high-quality service; and (3) perceived service quality was linked with customer satisfaction and loyalty.

**Boshaff and Gray (2004)** conducted their research on patients of private health organizations in South Africa and found that the service quality dimensions of nursing staff viz. empathy, assurance and tangibles have positive impact on the loyalty of patients.

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2.3. Hospital Management:

Organizations need to improve what they are currently doing as well as changing operations to what they should be doing, and after measuring the outcomes they should search for improvements on other new activities. Every improvement requires a change, either in small scale or in large scale, and every change requires an act of creation (Sommers, 1998).  

2.3.1. Quality control techniques:

Johan Thor and Bo Herrlin (2010) conducted a research study to measure effectiveness of quality improvement programmes. It was found overall, 58 percent of the program’s projects (39/67) demonstrated success. A greater proportion of projects led by female doctors demonstrated success (91 percent, n = 11) than projects led by male doctors (51 percent, n = 55). Facilitators at the hospital continuously adapted the improvement methods to the local context. A lack of dedicated time for improvement efforts was the participants’ biggest difficulty. The dominant benefits included an increased ability to see the “bigger picture” and the improvements achieved for patients and employees.

Six sigma is widely used quality control technique in manufacturing and service organization. It offers a way of measuring the performance capability of existing systems or processes. The higher the sigma level, the higher the performance of the healthcare system.

Patient satisfaction, physician satisfaction, reduced overtime, reduced patient wait times, increased revenues and an enhanced quality of life for healthcare personnel are some of the outcomes of moving to the higher sigma level. The goal is to move from the current state to a future, more productive state. By means of adopting six-sigma philosophy, the healthcare organization can achieve a cultural change. This will lead in realizing sustainable bottom-line results in the hospital. Mehmet Tolga Taner and Bulent Sezen (2007) made an attempt to give over wise of six sigma applications in healthcare industry at Turkey. Delays measurement and medical errors and variability

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often undermine the delivery of safe, effective patient care. Integrating the six-sigma culture into entire organizations by the commitment and involvement of top management can multiply the positive effects and make a significant impact at all levels. High level of internal communication is found necessary also necessary to facilitate the implementation of six sigma. The established Quality Improvement Team should collaborate with outside quality facilitators who can train them in deploying implementation and to provide necessary training for all project participants in system deployment, project management, and utilization of quality tools.

Ali Mohammad Mosadegh Rad (2005) investigated the success of TQM and barriers to its successful implementation in health care services organizations in Isfahan province, Iran, 2004. In this study descriptive and cross-sectional research was done via two questionnaires (TQM success and its barriers). The statistical population of this research consisted of all managers of health care services organizations who implemented TQM in their organizations (90 managers). It was found that TQM success in Isfahan health care organizations was high. The correlation analysis between the success of TQM and its principles, success, process management and focus on employees had a positive and the greatest effect and focus on material resources and on suppliers had a lower effect. In correlation analysis between the barriers to TQM and the problem dimensions, human resource, strategic and structural problems were the most important obstacles and barriers to TQM successful implementation respectively.

Qianmei (May) Feng and Chris M. Manuel (2008) Medical and policy literature reports many six sigma applications at specific healthcare organizations. However, there is a lack of studies that investigate the broader status of six sigma in US healthcare systems. The purpose of this paper is to present the results from a national survey of six sigma programs in US healthcare organizations. Assessed the implementation of six sigma in healthcare facilities. Two sets of surveys were designed based on whether an organization has adopted six sigma or not. Indicated the common six sigma projects

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implemented in healthcare organizations, typical implementation durations, cost benefits, and major barriers in implementation, and so on.

**P. Gary Jarrett, Kaiser, Jacksonville (2006)** conducted research study to recommend operational improvements to be achieved by implementing JIT Systems. In this particular study the cost and benefit outcomes achieved from a health care JIT implementation were compared with those achieved by the manufacturing, service, and retail industries. Chiefly, it was found that the health service market must be restructured to encourage greater price competition among priorities. A new standardization process should eliminate duplication of products and realize substantial savings.

Relatively speaking, there is a great deal of information and research done on the application of RFID technology into the healthcare sector (**Schwirn, 2006b, c**). To improve the healthcare supply chain by looking at possibilities of exploiting RFID technology. With improvements, end customers and patients may receive better service while mistakes in treatment of patients or underutilization of equipment in the hospitals can be minimized. Many existing studies also suggest that proper management of RFID technology implementation may enhance healthcare services and products by lowering costs, improving the quality of care, and make patient care. **Sameer Kumar, Eric Swanson and ThuyTran (2009)** showed that the cost of implementing current RFID technology was too expensive for broad and sweeping implementation within the healthcare sector at this time. Costs can be drastically reduced and justified with the proper collaboration within the supply chain. Improving relationships, sharing the high capital costs, and democratically choosing technological standards will improve the likelihood of end users saving money and receiving better service. However, several example applications had been identified in which this technology could effectively leveraged in a cost-effective way. RFID

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45 P. Gary Jarrett Kaiser, Jacksonville; LEADERSHIP IN HEALTH SERVICE (International health care logistics)

An analysis of international health care logistics The benefits and implications of implementing just-in-time systems in the health care industry; Leadership in Health Services Vol. 19 No. 1, 2006 pp. i-x.


technology has come a long way in the recent past and has potential to improve healthcare sector productivity and efficiency.

2.3.2. Components of Hospital Management:

A systematic approach measuring, tracking, monitoring and continuously improving efficiency, availability. There were three indicators availability (A), quality (Q) and efficiency (E). Healthcare organizations must monitor, track and improve these important aspects of their service operational system. The proposed approach intended to facilitate the systematic improvement at the different facets of operational effectiveness. **Carlos F. Gomes et al. (2010)**

**Dirk F. de Korne, Kees (J.C.A.) Sol, Thomas Custers (2009)** showed Quality control model (QCM) and care delivery value chain (CDVC) tools for hospital management to manage both on quality and cost outcomes in glaucoma care. Within the CDVC approach, QCM can be used to facilitate the choice between quality projects and provide focus on the potential reduction in costs of non-compliance. A reduction of costs per product by increasing the number of outpatient visits and surgery combined with a higher patient satisfaction. For CDVC to be supportive to an integrated quality and cost management, the notion “patient value” needs far more specification as mutually agreed on by the stakeholders involved and related reimbursement needed to depend on realized outcomes.

The hospital’s identity as a health community is slowly being transposed to that of an enterprise. Hospitals are getting bigger, are using relatively higher numbers of non-medical employees, their customers are becoming more critical, and they are operating in an increasingly competitive climate. **J.R.C. van Sambeek and F.A. Cornelissen (2010)** conducted a research study to find decision-making models for the design and control of processes regarding patient flows, considering

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various problem types, and to find out use of these models in decision making. A
total of 68 articles were selected. Of these, 31 contained computer simulation
models, ten contained descriptive models, and 27 contained analytical models. The
review showed that descriptive models are only applied to process design
problems, and that analytical and computer simulation models were applied to all
types of problems to approximately the same extent. Only a few models have been
validated in practice, and it seems that most models were not used for their
intended purpose i.e. to support management in decision making.

In 1996, two physicians at Harvard University concluded that “there is so far no
convincing scientific evidence that the application of the techniques of total quality
management in health care improves the quality of care in entire institutions or among
large numbers of physicians” (Blumenthal and Epstein, 1996)\(^{51}\).

Ranjita Misra and Arvind Modawal (2009)\(^{52}\) concluded that fewer Asian-Indian
physicians practiced in areas of high market penetration by managed care and have
moderate satisfaction with their ability to deliver appropriate and quality care. The
experience was categorized into physician satisfaction; service quality rating;
service limitations; difficulties acquiring and maintaining managed care contracts;
and financial impact.

Gunilla Johansson, Stockholm, Sweden and Christer Sandahl (2011)\(^{53}\)
described the perceptions of registered nurses (RNs), enrolled nurses (ENs), and
leaders (i.e. the first-line nurse manager, F-LNM and the) as to what characterises
an excellent work environment in a palliative care unit and the involvement of
leadership in that environment. Data were collected using two separate
instruments: a questionnaire, group interviews with nurses and leaders, and
documents at a palliative care unit. Qualitative content analysis was used to
analyze the material. The emerging categories found were: congruence in

in the future of quality management”, The New England Journal of Medicine, Vol. 335
No. 17, pp. 1328-31.

\(^{52}\)Ranjita Misra, Arvind Modawal, Bhagaban Panigrahi; Asian-Indian physicians ‘experience with
managed care organizations, International Journal of Health Care Quality Assurance Vol. 22
No. 6, 2009 pp. 582-599.

\(^{53}\)Gunilla Johansson, Christer Sandahl, Birgitta Andershed; Authentic and congruent leadership
providing excellent work environment in palliative care, Leadership in Health Services Vol.
24 No. 2, 2011 pp. 135-149.
leadership, mature group functioning; adequate organizational structures and resources; and comprehensive and shared meaning fullness. To accomplish the vision of good palliative care. Similarly in leadership, mature group functioning, adequate organisational structures and resources, and comprehensive and shared meaningfulness were identified as essential components for fulfilling the vision.

Business Process Reengineering (BPR) as fundamentally rethinking and radically redesigning business processes to achieve dramatic improvements in critical contemporary performance measures such as cost, quality, service and speed. BPR, also known business transformation and process change management. They found BPR, like other single approached to improve service quality, were likely to be unsuitable for health care, which is comprised of a number of sub processes. It has many stakeholders at different levels and there is wide variation in its internal customer (e.g., fellow professionals) and external customer (i.e. patients) needs. (Anjali Patwardhan and Dhruv Patwardan, 2008)  

2.3.3. Hospital governance
Corporate governance has been widely studied and has been identified as an important determinant of organizational performance (Abor and Adjasi, 2007; Abor and Biekpe, 2007). Health care organizations are looking to the leadership abilities of their employees to ensure their success (Bodinson, 2005; Kim, 2007; Melum, 2002). Leadership development initiatives are a key strategy utilized to maximize leadership behaviours; such initiatives often include sending employees to leadership development programs (Block and Manning, 2007; Groves, 2007; Sharlow et al., 2009).

Hospital governance has been defined to include the responsibility and accountability for the overall operation of an organization (Bohen, 1995). More specifically, hospital governance has been conceived of as a shared process of top-level organizational leadership, policy making and decision making. Although the governing board has the ultimate accountability, the CEO, senior management and clinical leaders are involved in top-level functions (Bader, 1993; Alexander et al., 2003). Much of the efforts have been done to implement patients’ centric approach, but this culture is not fully flourished. The observation of the office space revealed that there is a lack of patient-centric artefacts in the corporate environment; this needs to be corrected to align visual symbols with corporate vision and to reinforce the patient-centric culture for the employees. (Steven H. Appelbaum, Seyed Mahmoud Zinati, 2010).

Nancy Phaswana-Mafuya, George Petros, Karl Peltzer, (2008) identified service gaps were understaffing/lack of capacity, difficulty in retaining and recruiting staff, service disparities, inaccessibility of services/low-service utilisation and limited funding. It was believed that NPOs could fill these gaps. About 83 per cent perceived the relationship between government and NPOs as good. Contract monitoring, quality of service, communication and quality control were said to be unsatisfactory. The majority of sub-districts (11) indicated that they provided supplies to NPOs; 50 per cent perceived the relationship between the sub-districts and NPOs as good or very good. NPOs have critical role to play in PHC service delivery.

Rubin Pillay (2008) addressed the problem of providing managers in both the public and private sectors with the requisite competencies to help increase efficiency, effectiveness and responsiveness in the delivery of health services. A cross sectional

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64Steven H. Appelbaum, Seyed Mahmoud Zinati, Andrew MacDonald and Yusef Amiri (2010), ‘Organizational transformation to a patient centric culture: a case study’; Leadership in Health Services Vol. 23 No. 1, 2010 pp. 8-32.
survey using a self administered questionnaire was conducted among hospital managers in South Africa. Respondents were asked to rate the level of importance that each proposed competency had in their job and to indicate their perceptions about the adequacy of health management training programs in South Africa. Hospital managers in both sectors felt that people management and self management skills were the most valuable for the efficient and effective management of hospitals, followed by “hard management skills” and skills related to the ability to think strategically. Specific skills or knowledge related to health care delivery were perceived to be least important. Public sector managers were also more likely to seek future training, and were also more adamant about the need for future management development programs.

Subhasis Ray Amitava Mukherje (2007) conducted a research study to explore the route map for employing efficient e-governance so that at least existing resource and infrastructure are better utilized and deficiencies were tracked for future planning. National health is one of the most important factors in a country’s economic growth. India seems to be a victim of the vicious cycle around poor economy and poor health conditions. A detailed study was carried out to find out India’s healthcare infrastructure and its standing in e-governance initiatives. After consolidating the fact that effective e-governance can enhance the quality of healthcare service even within limited resources, authors explored success and failure factors of many e-governance initiatives in India and abroad. Finally, an e-governance framework is suggested based on the above factors together with the authors’ own experience of implementing e-governance projects in India and abroad. The suggested framework is based on a phased implementation approach. The first phase “Information Dissemination” is more geared towards breaking the “digital divide” across three dimensions: G2Business; G2Citizen; and G2Agent. The most advanced stage is aimed towards joining up healthcare information across the above three dimensions and drawing meaningful analytics out of it.

Principle eight is known as “self-improvement and quality of management”. To ensure total quality management, continuous improvement as an organizational philosophy needs to permeate all aspects of the hospital (Taylor, 2000). This is tested in public and private sector hospitals’ governance. The results of the study revealed numerous differences in the governance structures in private and public hospitals. Public hospitals employ large board size compared to the private hospitals. The results obtained were analyzed and discussed to ascertain the extent to which the governance structures in these hospitals conform to Taylor’s principles of good governance. The results of the study revealed numerous differences in the governance structures in private and public hospitals in Ghana. From the review of Taylor’s principles of good governance and the comparative case analysis, it was observed that some of the principles are not present in the current hospital governance systems (Joshua Abor, 2008).

The two dimensions of institutional culture identified for this study were character and leadership. The character of an institution was the unique identity of the institution that distinguishes it from other institutions. It includes the “symbols, myths, visions, pride, and the accomplishments of its past and present heroes” (Lusthaus et al., 1999). Leadership is very important to the success of any institution. Lusthaus et al. (2002) defined leadership as “the process through which leaders influence the attitudes, behaviors and values of others towards organizational goals” (Lusthaus et al., 2002).

2.3.4. Organizational Culture:

Hospitals apply several ways to improve quality such as flourishing culture that enhances quality, attracting, and retaining qualified people, and empowering

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72 Ibid 84
employee (Silow-Carooll et al., 2007)\textsuperscript{73}. The success of quality improvement endeavors is expected to rely heavily on the type of organization culture (Ginsburg, 2003)\textsuperscript{74}. Organizational culture was conceptualized as a construct that consists of three distinctive subcultures: bureaucratic, innovative, and supportive (Wallach, 1983)\textsuperscript{75}. In bureaucratic culture, there are clear lines of authority and hierarchy, and work is highly regulated and systemized. Innovative culture is characterized as involving creativity, freedom, results-oriented, and risk-taking. Supportive culture provides friendly and warm environment where employees tend to be open, fair, and honest. Quality improvement focuses mainly on leadership support, processes, human resource, information, customer focus, and innovation to achieve high quality in health care organizations (Meurer et al., 2002)\textsuperscript{76}. Organizational culture has been defined as shared behaviours, values, and beliefs that are learned by the members of an organization (Lawson and Ventriss, 1992)\textsuperscript{77}. Organization culture has the potential to shape attitudes, reinforce beliefs, direct behaviour, and establish performance expectations. The best organizations have strong cultures that encourage adaptability and continuous improvement in all areas of operation (Adams, 2009)\textsuperscript{78}. Each organization usually has a dominant culture, which expresses the core values that are shared by a majority of its members. Bureaucratic subculture is usually dominated by rules, regulations, and orders, where employees are requested to perform tasks as specified without freedom or autonomy. The innovative subculture, in contrast, values the talents, ideas, and creative potential of all members.

2.4 Service Quality

Service quality is a principle component of customer satisfaction. Consumer’s perception is the main determinant of quality in health care service. Most of the researchers on that issue believe that there is a relationship between the perception of the consumers on the quality of the services and their satisfaction (Cronin & Taylor, 1994).  

Quality of health care is the most optimal degree of health outcomes by delivery of effective, efficient and cost-benefit professional health services to people and communities.

As there are many alternatives to patients for hospital choices. If they are not satisfied with one they can easily choose another provider. Conceptualizing and measuring customer satisfaction and service quality in a health care setting more important and simultaneously more complex (Taner and Antony, 2006).  

Almost all studies stress the importance of patients’ views as an essential tool in the processes of monitoring and improving quality of healthcare services. Many hospitals increasingly are adopting a patient-centered attitude (Hendriks et al., 2002).  

Applying quality management tools and techniques to improve performance is relatively new to intensive care services. Peer-review process, a common method to identify ICU defecates. Seetharaman Hariharan, Prasanta Kumar Dey (2010) introduced a quality management framework by combining cause and effect diagram and logical framework. An intensive care unit was identified for the study. They found that patients improved infrastructure, state-of-the-art equipment, well maintained facilities, IT-based communication, motivated doctors, nurses and support staff, improved patient care and improved drug availability were considered the main

project outputs for improving performance. The proposed framework was used as a continuous quality improvement tool, providing a planning, implementing, monitoring and evaluating framework for the quality improvement measures on a sustainable basis.

**Barbara Treris (2010)**

tried to describe the intentional and sustained strategy of Providence Health Care to build a culture focused on quality, safety and innovation. It was that found that the journey was in progress, significant improvements have been accomplished.

**Sameer Kumar, Neha S. Ghildayal and Ronak N. Shah (2011)**

studied quality and efficiency of U.S. healthcare services. The impact of quality and efficiency was examined on various stakeholders to achieve the best value for each dollar spent for healthcare. It was found that the U.S. healthcare system was of vital interest to the nation’s economy and government policy (spending). The U.S. healthcare system was characterized as the world’s most expensive yet least effective as compared to other nations.

Growing healthcare costs had made millions of citizens vulnerable. Major drivers of the healthcare costs were institutionalized medical practices and reimbursement policies, technology induced costs and consumer behaviour.

**Amira Elleuch (2008)**

tried to measure patient satisfaction in Japan. Japanese healthcare service quality was evaluated using its process characteristics (patient-provider interaction) and physical attributes (settings and appearance). Process quality attributes found to be patient satisfaction antecedents. Satisfaction in turn predicts patient intentional behaviour (to return and to recommend). Japanese society cultural specificity seems to be an interesting background to understand Japanese evaluation when patients assess health service quality.

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83Barbara Treris (2010), ‘Establishing an organizational culture to enable quality improvement’; Leadership in Health Services Vol. 23 No. 2, 2010 pp. 130-140.
Quality of health care is the degree of the most optimal degree of health outcomes by delivery of effective, efficient and cost-benefit professional health services to people and communities.

Bodil Wilde-Larsson (2009) found approximately 10 per cent hesitated about continuing to visit the same care provider. Favourable service quality evaluations made a statistically significant contribution to the odds of reporting no hesitation about re-visiting the same primary healthcare centre.

To address today’s concerns with fragmentation of health services and uncoordinated patient care the solution again often proposed is the development of integrated delivery systems. There should be integrated delivery systems with incentives for teams of professionals to provide coordinated, efficient, evident-based care.

Havva Çaha (2010) found Patients preferred private hospitals due to their belief that private hospitals provide qualitative health service in Turkey. But this did not mean that they encounter sufficient services. On the contrary, a large number of patients complain about services given by private hospitals. The complaints were mainly about the length of the time that they wait for treatment and the consultation time given to them. As a result, this study indicated that satisfaction of the patients seem to be the most important factor for the private health care providers.

Masood A. Badri and Samaa Taher Attia (2008) found that if patients were given information about their condition and about how to look after themselves in future, it would help them to assume greater responsibility for their health. It was found that both availability and access of resources; and rules, regulations and administrative matters were important. Competency, knowledge, reliability and trust; professionalism and courtesy; empathy and personal attention; and tangibles and facilities formed a construct (named Care quality) proved important in third model. The final recommended model was based on three constructs – quality of care,

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process and administration, and information. The goodness-of-fit statistics supported the basic solution of the healthcare quality-satisfaction model.

Patients are usually in disequilibria when it comes to illness, which means that they are not thinking in their normal pattern (Potter and Perry, 1997). This, in turn, affects not only the individual but also the family, work environment and society as a whole. In the current business environment, relationship marketing has become an important aspect of doing business. This is especially true for a service business where high amount of customer-employee relationship can influence the consumption of services offered. Keeping a good relationship with customers is crucial for the success of the business because it has the potential to increase customer retention rates.

2.4.1 Importance of Customer Relationship

It can be ten times more expensive to win a customer than to retain a customer – and the cost of bringing new customer to the level of profitability as the lost one is up to 16 times more (Lindgreen et al., 2000). In any situation involving people, one aspect that needs to be given proper attention is interpersonal relationship. Based on the inseparability characteristic of service, naturally service has significant impact on customers. When a service is difficult to evaluate, consumers often look too their cues, such as aspects of interaction or interpersonal method in assessing service quality (Parasuraman et al., 1985). Relationship quality is viewed as a bunch of intangible value that increases products or services and results in an expected interchange between buyers and sellers.

2.4.2. Importance of Respect:

The word “respect” is common in our everyday usage. As mentioned earlier, the word is very commonly used and each time when “respect” is mentioned, it is as if everyone understands. On the other hand, in the actual academic world, to understand “respect” is very complex. Even though the term respect is widely used in the society, its dimensions and operationalization are unclear. Even though respect can be

considered as an “old” concept judging from the extensive usage of the word itself, respectful behaviours actually varies by dentition and making it a deceiving complex concept after all (Sung, 2004). Respect may be viewed as caring which has the feeling of care and loving towards others. Marketers always respect customers. It is unique blend of morality, compassionate, responsive and caring for other individual (Dillon, 1992). Care is known as “meeting the others morally” (Noddings, 1984).

Dillon (1992) proposes a concept with three dimensions; namely attention and valuing of the particularity, understanding and responsibility. Dillon believes the combination of the three dimensions will produce a kind of respect that we (as individuals) owe to all, and not just our loved ones (1992). The dimensions of respect in this study include: (1) attention and valuing; (2) understanding; and (3) responsibility. It involves an acceptance of the differences of others that goes beyond toleration. Attention here also carries the need to be sympathetic, cherishing and concern to be involved in engagement with participation of others. All in all, this dimension urges the need to value differences in others and of viewing it as a barrier to be overcome (Dillon, 1992).

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ibid


Dillon, R.S. (1992), “Care and respect”, in Cole, E.B. and Coultrap-McQuin, S. (Eds), Explorations in Feminist Ethics, Indiana University Press, Bloomington,
A quasi-experimental design was used. An experimental and control group (of patients) were surveyed before the changes in servicescape took place, and a further experimental and control group of patients were surveyed after changes in the servicescape. The results indicated the positive effect that the change in the servicescape had on the overall perceptions of service quality, as well as on some of the individual dimensions. In this study, it was possible to determine the specific effects that changes in physical evidence had on the perceptions of service quality as a whole, as well as on the various dimensions. The study confirmed the role of physical evidence in the patient’s perceptions of service quality, as well as in the patient’s perceptions of the reliability and responsiveness dimensions.

2.4.3. Rapport

Rapport is such a familiar concept that almost everyone can identify with. It is a human interaction including marketing, psychology and education. Many studies have been done in education. In marketing management rapport is studied from selling

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point of view. The definition by Gremler and Gwinner (2000)\(^9\) was much more relevant to marketing. They defined rapport as the character of the interaction between employees and customers. Among others, they suggested that rapport consists of two important dimensions; namely enjoyable interaction and personal connection. Both were perceived by customers and employees as important in the development of relationships in service contexts. Enjoyable interaction refers to “an affect laden cognitive evaluation of one’s exchange with employee.”

Recent changes in the competitive environment have forced industries to formulate new strategic responses. Service quality is a multi-dimensional construct. Thus, service quality may be viewed based on the different attributes of the service delivery system in different operational context. These responses are known as operational philosophies aimed at improving internal efficiency and external effectiveness. These philosophies included quality improvement initiatives such as, total quality management (TQM), just in time (JIT), continuous improvement (CI), job reengineering (JR), process reengineering (PR), organizational restructuring (OR), benchmarking (BM), among others. Jafar Alavi and Mahmoud M. Yasin (2008)\(^9\) aimed at understanding the effective implementation of quality improvement initiatives in different service operational settings. With the specific environmental, strategic and operational realities and challenges faced by healthcare related organizations this study specifically attempted to shed some light on the role of effective implementation of quality improvement initiatives in addressing the operational, environmental and strategic challenges faced by these organizations. The results of the environmental changes factor analysis tend to confirm the current environmental changes faced by most healthcare related organizations. It is to be noted that the customer, innovation and governmental regulations represent the backbone of these environmental changes. The results of factor analysis related to strategic options appeared to indicate that the studied organizations were aware of these challenges, as they had developed quality improvement-based strategies to deal with such environmental changes. Finally, the effectiveness of the implemented


quality improvement initiatives, both in terms of operational outcomes, as well as strategic outcomes appeared to be the norm rather than the exception.

Fig. 2.2 Quality improvement strategies

Source: JafarAlavi and Mahmoud M. Yasin (2008)

Hospitals are required to provide patients with the highest quality service at the lowest possible cost. Both public and private health organizations face several challenges that force them to be more customer-focused and to be highly responsive to global changes. Accordingly, health care organizations are forced to respond to the growing pressure on the health system for demonstrably high and ever improving standards of care and services (Balding, 2007). Patient safety and quality improvement are becoming important criteria for accreditation decisions by international and local health care organizations around the world. Indeed, the primary objective of quality improvement in health organizations is to provide excellence for patients through continuous improvement of services.

Quality improvement is an organization wide commitment that entails the training and involvement of all employees in quality-related activities. Quality improvement should cover all processes conducted in health organizations. Because quality improvement is concerned clearly with making the process better instead of blaming people, it requires that employees understand the nature of the core processes used to

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100 Bading, M. (2007), A Model for Middle Manager: Led Quality Improvement in Health Care, The Royal Victorian Eye and Ear Hospital, Melbourne.
provide health care. In addition, the hospital’s investment in the people and the systems are necessary to measure and improve quality (Craven et al., 2006)\textsuperscript{101}.

Raed Ismail Ababaneh( 2010)\textsuperscript{102} The study results revealed that innovative culture plays a stronger role compared with bureaucratic and supportive cultures in quality improvement practices in Jordanian public hospitals. Contrary to previous research (Kissam et al., 2003)\textsuperscript{103}, bureaucratic culture showed a positive correlation with each dimension of quality improvement. Compared with bureaucratic and supportive cultures, innovative culture appears to play a stronger role in quality improvement practices. Contrary to expectations, the analysis showed that bureaucratic actions enhance rather than hinder quality improvement practices.

Consumers may get free and easy health information from the Internet or advertisements this has changed the traditional dynamics between patients and physicians. Managed care offers an open access to and broad choice of providers to the patient. Thus, the healthcare market has become a consumer-driven market under the managed care system. Marketing information system can facilitate the providers to redesign areas for improvement and enhancement of their caring process and, in turn, patient satisfaction.

Sandra S. Liu, Hyung T. Kim, Jie Chen And Lingling An(2010)\textsuperscript{104}

In this study, there were five CQAs, or factors identified: Communication and Empowerment, Compassionate and Respectful Care, Clinical Reputation, Care Responsiveness, and Efficiency. The promotion detraction matrix demonstrated the stronger promotion effects of Compassionate and Respectful Care and Efficiency; and major detraction effect of Clinical Reputation and Communication and Empowerment. That was, improving Compassionate and Respectful Care and

\textsuperscript{102}Raed Ismail Ababaneh( 2010), ‘The role of organizational culture on practising quality improvement in Jordanian public hospitals’; Leadership in Health Services Vol. 23 No. 3, 2010 pp. 244-259.
Efficiency could significantly promote the recommendation of the service; whereas lowering the perceived level Clinical Reputation, Communication, and Empowerment would detract patients from recommending or utilizing the services.

Quality improvement is an important aspect of any service but sometimes specific quality improvement process changes may have little impact on an organization’s bottom line and may actually reduce employee satisfaction and thus bottom-line performance. (Anne S. York and Kim A. McCarthy, 2011)\textsuperscript{105}

2.5. SERVQUAL

According to the SERVQUAL model, the quality is determined by evaluating the relationship between the expected and the actual and a reflection of the deviations. Marketers advocate a functional approach when it comes to measuring service quality. Parasuraman et al. (1985)\textsuperscript{106} observed that service was difficult to anticipate and comprehend what aspects insinuate high quality to consumers, and the levels of those aspects that required to deliver high-quality service.

2.5.1. SERVQUAL as power tool:

Customer satisfaction and service quality research is dominated by SERVQUAL, which suggests that service quality is fundamentally a gap between customer expectations regarding a service provider’s general class and their estimation of its actual performance (Parasuraman et al., 1991a)\textsuperscript{107}

The original objective in the development of SERVQUAL was to try to provide an instrument for measuring service quality that could be used across a broad range of services and industries with only minor modification. SERVQUAL to date has been applied across a range of private sector organizations (Babakus& Boiler, 1992; Bouman& van der Wiele, 1992; Candlin& Day, 1993)\textsuperscript{108}


In their study, Reidenback and Sondifer-Smallwood\textsuperscript{109} identified patient confidence as one of the dimensions affecting patient satisfaction in all the above-mentioned three settings. Patient confidence also influences the perception of service quality in both the inpatient and outpatient settings.

The SERVQUAL instrument of Parasuraman et al. (1988)\textsuperscript{110}, a 22-item scale that measures service quality along dimensions, forms the keystone for all the other works. Though the effectiveness of SERVQUAL in evaluating service quality has been questioned by different authors for diverse reasons, there is a general agreement that the 22 items are reasonably good predictors of service quality in its entirety. The SERVQUAL was designed using the five nursing services identified in other studies as the essential elements in providing a quality nursing service. These elements are: tangibles, reliability, responsiveness, assurance and empathy.

Johnstone (1995)\textsuperscript{111} extended the five generic dimensions of SERVQUAL up to eighteen quality dimensions viz. cleanliness, aesthetics, comfort, functionality, reliability, responsiveness, flexibility, communication, integrity, commitment, security, competence, courtesy, friendliness, attentiveness, care access and availability.

Lim and Tang (2000)\textsuperscript{112} developed a modified SERVQUAL model considering six dimensions viz. tangibles, reliability, assurance, responsiveness, empathy, accessibility and affordability. They have put emphasis on affordability of patients relating to their satisfaction.

SERVQUAL provides service managers and associated decision-makers not only with information on customer perceptions of current service delivery but also on their expectations, thus enabling a closer matching of service delivery to expectations and needs. Similarly, the SERVQUAL instrument is capable of application to different customer


groups of the same service provider, again allowing better informed prioritization and priority conflict resolution. (Mik Wisniewski & Mike Donnelly, 1996)\textsuperscript{113}

Especially in the event of time and resource constraints, the SERVQUAL scale is able to direct managerial attention to service areas which are critically deficient from the customers’ viewpoint and require immediate attention. No doubt, the SERVQUAL scale entails greater data collection work. (Dabholkar, Shepherd and Thorpe, 2000)\textsuperscript{114}

SERVPERF, is named expectation (E) component of SERVQUAL be discarded and instead performance (P) component alone be used. They proposed what is referred to as the ‘SERVPERF’ scale. Besides this is the SERVQUAL scale which entails superior diagnostic power to pinpoint areas for managerial intervention. The obvious managerial implication emanating from the study findings is that when one is interested simply in assessing the overall service quality of a firm or making quality comparisons across service industries, one can employ the SERVPERF scale because of its psychometric soundness and instrument ungenerousness. However, when one is interested in identifying the areas of a firm’s service quality shortfalls for managerial interventions, one should prefer the SERVQUAL scale because of its superior diagnostic power. No doubt, the use of the weighted SERVQUAL scale is the most appropriate alternative from the point of view of the diagnostic ability of various scales, yet a final decision in this respect needs to be weighed against the gigantic task of information collection. (Sanjay K Jain and Garima Gupta, 2004)\textsuperscript{115}

Mik Wisniewski & Mike Donnelly (1996)\textsuperscript{116} found V.Parasuraman et al. designed the SERVQUAL instrument to apply across the spectrum of service environments with a minimum of adaptation. The underlying structure of the SERVQUAL instrument appeared well suited to assessing service quality in a public sector context.


\textsuperscript{115}Sanjay K Jain and Garima Gupta(2004), Measuring Service Quality: SERVQUAL vs. SERVPERF Scales; VIKALPA • VOLUME 29 • NO 2 • April - June 2004 p.p25-37.

Potentially, it provided service managers and associated decision makers not only with information on customer perceptions of current service delivery but also on their expectations, thus enabling a closer matching of service delivery to expectations and needs. Similarly, the SERVQUAL instrument was capable of application to different customer groups of the same service provider, again allowing better informed prioritization and priority conflict resolution. However, it was evident that further applications of SERVQUAL to public sector services are required to assess the portability and reliability of the approach. It appeared that further applications of the SERVQUAL instrument to other public sector services and across different customer groups for a particular service helped in the evaluation of the suitability of the existing instrument.

2.5.2. SERVQUAL in Healthcare sector:

Wan Edura Wan Rashid (2009) revealed SERVQUAL appeared to be a consistent and reliable scale to measure healthcare service quality. In principle, together with the information relative significance of service quality dimensions, it helped health care organization to identify where, and to some extent how, to improve the service they offered to patients. Given the importance of functional aspects of care, the SERVQUAL instrument had a useful diagnostic role to play in assessing and monitoring service quality in health care, enabling the organization to identify where improvements are needed from the patient’s viewpoint.

Hardeep Chahal (2007) worked on the case study of Civil Hospital Ahmedabad. The data was collected from 205 indoor patients of four departments namely general medicine, orthopaedic, paediatrics, obstetrics and gynaecology. Inter and intra relationship among the measures of service quality and patient loyalty were analyzed by using relevant statistical tools to draw out inferences. Among the three patient loyalty components, using provider again for the same services is found to be more significant followed by using provider again for different services and recommending providers to others in relation to overall service quality as dependent variable, and

beta values are figured out as 0.15, 0.12 and 0.09 respectively. The 35% R Square value for the model service quality – patient loyalty model indicate weak predictive power of this model. However at the same juncture the study found that no significant difference in the patients’ perceptions with respect to patient loyalty and quality and per se, may be concluded that both are identical measures. Alternatively the more satisfied the patients are with the quality of their interactions with staff, the more likely they are going to take treatments for similar and different medical problems and would recommend the provider to their relatives and friends.

Rooma Roshnee Ramsaran-Fowdar (2008)\textsuperscript{119} used a new service quality instrument called PRIVHEALTHQUAL emerged from the study, based on factor and reliability analysis. The “reliability and fair and equitable treatment” factor was found to be the most important healthcare service quality dimension.

Shyh-Jane Li, Yu-Ying Huang, Miles M. Yang (2011)\textsuperscript{120} examined whether satisfaction moderates the relationship between service quality and behavioural intentions. A structured questionnaire was distributed to the out-patients of 12 regional hospitals (the middle level) in Taiwan. The findings showed that the different dimensions of service quality (i.e. reliability, responsiveness, assurance, and empathy). Satisfaction was positively moderated the influence of reliability/empathy on behavioural intentions, but negatively moderates the relationships between responsiveness/assurance and behavioural intentions. This study revealed the moderating role of satisfaction in the translation from service quality to behavioural intentions in health care services. Moreover, the natures of the moderating effects are not the same for different service quality dimensions.

Shieu-Ming Chou, Thai-Form Chen, Beth Woodard(2005)\textsuperscript{121} studied to determine the extent of disconfirmation of the perceived quality of nursing services, and its relationship to patient’s satisfaction, intent to return, and intent to recommend

\textsuperscript{120} Shyh-Jane Li, Yu-Ying Huang, Miles M. Yang (2011), ‘How satisfaction modifies the strength of the influence of perceived service quality on behavioral intentions’; Leadership in Health Services Vol. 24 No. 2, 2011 pp. 91-105
\textsuperscript{121} Shieu-Ming Chou Zhai-Form Chen, Beth Woodard, Miao-Fen Yen, Using SERVQUAL to Evaluate Quality Disconfirmation of Nursing Service in Taiwan; Journal of Nursing Research Vol. 13, No. 2, 2005p.p75-83.
to others. The results revealed age, gender, and education levels of patients as major influences on individual perceptions of nursing care. Empathy was one service across all sites that constantly scored highest in terms of satisfaction, both on the SERVQUAL and in the interviews.

Simon S. K. Lam (1997) found SERVQUAL appeared to be a consistent and reliable scale to measure health care service quality. The scale exhibited reliable and valid measures of patients' expectations of health care services and their perceptions of the health care providers' performance level. The results pinpointed areas for attention to improve health care service quality. First, they indicated that perceived service performance generally falls short of idealized expectations except in the physical elements of service quality. Timely, professional and competent service was what the customers expect from health care providers, and although hospitals in Hong Kong were generally provided good services in these three areas, improvements were still needed to meet patients' expectations. The results also indicated patients' perception that hospital staff showed not enough caring and that they were not provided with individualized attention. These were the areas that hospitals should have improved in order to build a patient focused attitude towards service delivery.

Healthcare service quality research, using the SERVQUAL model, brings mixed results. Few have found SERVQUAL a reliable instrument, while others suggest there are certain healthcare service dimensions that are not captured by the original SERVQUAL scale (Babakus and Mangold, 1992). Therefore, it is important to tailor the SERVQUAL scale to a sector’s specific needs, culture or nation. (Mohsin Muhammad Butt, Ernest Cyril de Run, 2009).

Mohsin Muhammad Butt and Ernest Cyril de Run (2010) examined of 340 randomly selected participants visiting a private healthcare facility during a three-month data collection period. Data were analyzed using means, correlations, principal

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125 Ibid95
component and confirmatory factor analysis to establish the modified SERVQUAL scale’s reliability, underlying dimensionality and convergent, discriminant validity. Results indicated a moderate negative quality gap for overall Malaysian private healthcare service quality. Results also indicated a moderate negative quality gap on each service quality scale dimension. However, scale development analysis yielded excellent results, which could be used in wider healthcare policy and practice.

Nowadays hospital are turning towards contracting options in order to reduce the amount of capitation that goes into funding for laboratory work, technical support and other services. Kidney dialysis machines, magnetic resonance imaging, transplant techniques, nuclear medicine and high dosage chemotherapy are examples of technological advances in recent years. Many of these technological advances involve highly specialized and expensive equipment. When hospitals invest in equipment, hospital costs – the most rapidly escalating element of healthcare costs – must then increase. Medical professionals and their patients by the quality of the healthcare professionals who serve them judged hospitals. The results suggested that specialty hospitals were significantly more efficient than general hospitals. Overall, general hospitals were found to be more than twice as inefficient compared with specialty hospitals in the sample. (Sameer Kumar, 2010)126

**Woo Hyun Cho, Hanjoon Lee, Chankon Kim, Sunhee Lee (2003)127** examined the relative impact of four service quality dimensions on outpatient satisfaction and to test the invariance of the structural relationships between the service quality dimensions and satisfaction across three patient groups of varying numbers of prior visits to the same hospital as outpatients. Survey of 557 outpatients using a self-administered questionnaire over a 10-day period at a general hospital in Sungnam, South Korea. Patients answered questions related to two main constructs, patient satisfaction and health care service quality. The health care service quality measures (30 items) were developed based on the results of three focus group interviews and the SERVQUAL scale, while satisfaction (3 items) was measured using a previously validated scale.

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Confirmatory factor analysis was used to assess the construct validity of the service quality scale by testing convergent and divergent validity. A structural equation model specifying the four service quality dimensions as exogenous variables and patient satisfaction as an endogenous variable was estimated to assess the relative impact of each of the service quality dimensions on satisfaction. This was followed by a multi-group LISREL analysis that tested the invariance of structural coefficients across three groups with different frequencies of outpatient visits to the hospital. Findings supported the causal relationship between service quality and satisfaction in the context of the South Korean health care environment. The four service quality dimensions showed varying patterns of impact on patient satisfaction across the three different outpatient groups.

Dr Markanday Ahuja et al. (2011) conducted a research study and results indicated that the SERVQUAL scale could make a valuable contribution by enhancing the understanding of the perceived quality of eye care services. The measurement scale also served to identify symptoms and the underlying problems that inhibit the effective provision of quality eye care services. Be in a better position to anticipate patients’ requirements rather than to react to patient’s dissatisfaction. Respondents to be the most important dimensions of service quality had identified the attributes of reliability and assurance. The responsiveness & tangibility dimensions were found to have negative gap (perception minus expectation), implying that patients expectation of these two dimensions of the eye care services are not met by eye hospitals in Haryana.

SERVQUAL is used to advice decision makers and policy makers regarding improvements needed regarding patients’ expectation and perception. The highest expectation and perception and lowest gap of quality is related to the tangibles dimension, showing that the private hospitals have paid attention to the physical aspects and infrastructures of care delivery. Their findings confirm two previously carried out study results in Singapore and Malaysia. (Asghar Zarei1, et al. 2012)

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Coskun Bakar and H. Seval Akgun (2008)\(^{130}\) applied SERVQUAL scale was implemented into routine use at the Baskent University Hospitals Network in Baskent, Turkey. The study consisted of 550 randomly chosen patients who presented to any member hospital in that network during January and February 2006 and received treatment as inpatients or outpatients at those healthcare facilities. The SERVQUAL scale was utilised to evaluate hospital services. The study extracted the perceived scores of the patients were higher than expected for an ordinary hospital but lower than expected for a high-quality hospital. The highest difference between the perceived service score and the expected service score was found at the Alanya Application and Research Center in Alanya, Turkey. The paper demonstrated the use of the SERVQUAL scale in measuring the functional quality of the hospitals assessed.

Lam (1997)\(^{131}\) examined the validity, reliability and predictive validity of SERVQUAL and analyzed its applicability to the health sector in Hong Kong. The study result proved that SERVQUAL is a reliable model to measure health care service quality. However, factor analysis on five dimensions indicated that the scale could be treated as one-dimensional for the results identified one dominating factor representing expectations and perceptions.

Jaboun and Chaker (2003)\(^{132}\) conducted a comparative study on public and private hospitals at UAE. Their research result revealed that there was a significant differences between private and public hospitals in terms of overall service quality in empathy, tangibles, reliability and administrative responsiveness. They conducted a comparative analysis between private and public hospitals and pointed out that public hospitals were perceived to be better than the private hospitals as far as service quality is concerned. Kilbourne et al. (2004)\(^{133}\), in his study, proved that SERVQUAL is capable of capturing even slight quality indicators in a multidimensional way, namely, tangibles, responsiveness, reliability and empathy as well as overall service quality.


Qin et.al.(2009)\textsuperscript{134} considered the perceived quality as one of the antecedents of patient satisfaction and compared perceived quality with the expected service quality on the basis of SERVQUAL model to measure the satisfaction level of a patient regarding waiting time in a hospital. They considered a hypothesis that the service quality directly and positively influences patient satisfaction. They were also able to prove that the service quality is one of the antecedents of patient satisfaction.

Lim and Tang(2000)\textsuperscript{135} measured satisfaction of 252 patients in hospitals of Singapore by applying modified version of SERVQUAL and found that the hospital needed improvements across all six dimensions viz. tangibles, reliability, assurance, responsiveness, empathy and affordability.

Wong (2002)\textsuperscript{136} pointed out that three dimensions viz. responsiveness, assurance and empathy of SERVQUAL model were more important factors than other two dimensions affecting overall patient satisfaction.

Karassavidou et.al. (2007)\textsuperscript{137} applied SERVQUAL model to measure a service quality on three dimensions viz. a) human aspects, b) physical environment and infrastructure of the care unit and c) access. They applied a modified version of SERVQUAL model where demographic features of patients (age, gender, education and income) have been taken into account.

Mahmood Nekoei-Moghadam and Mohammadreza Amiresmaili (2011)\textsuperscript{138} assessed hospital service quality. The present descriptive study was carried out through a cross-sectional method in 2008. The participants of this study were patients who had been referred to Kerman University of Medical Sciences hospitals. The sample comprised 385 patients, the data were collected by SERVQUAL as a standard

\begin{thebibliography}{9}
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questionnaire, and data analysis was carried out on 385 completed questionnaires. In all five dimensions of quality, a gap was observed between patients’ perceptions and expectations as follows: Assurance: 21.28, Empathy: 21.36, Responsiveness: 21.80, Tangibles: 21.86 and Reliability: 21.69. A paired T-test showed that the differences between quality perceptions and expectations are significant (p value , 0.05). Based on the findings of this research, the hospitals in the study did not meet the expectations of patients and were unable to provide health care services according to patients’ expectations. Hence rearranging the service delivery and deploying better facilities and equipment in order to decrease the gap between patients’ perceptions and expectations may be helpful.

Despite its critics, SERVQUAL has been widely used in many service industries including hotels, travel, higher education, real states, accountancy, architecture, construction services, hospitals, dentistry, call - centers (Foster, 2001)\textsuperscript{139}. Indeed, in health care most studies that explore quality apply SERVQUAL. The focus of these studies varies and refers to: identification of the dimensions of service quality and assessment of the level of quality provided by hospitals or across a number of service categories provided by the hospital (Mostafa, 2006)\textsuperscript{140}.

2.6 Conclusion:

The main objective of any healthcare system is to facilitate the achievement of optimal level of health to the community through the delivery of services of appropriate quality and quantity. The level of competition has increased in health care sector. Patients’ satisfaction is emphasized highly in competitive market.

From the literature review on patients satisfaction, hospital management , hospital governance, service quality and SERVQUAL in health care industry, it is observed majority of the authors studied only a particular one hospital i.e. multi-specialty hospital or special hospital. Few of them have done comparative analysis of private and public hospital. In some studies only service quality is studied and hence the scope of these studies becomes limited. In this research factors influencing choice of


hospital and service quality is measured. And also satisfaction level and patients’ loyalty also studied. In addition to that analysis on Service Quality model given by Parasuraman et al. is also included which highlights important dimensions of services which the private Hospitals need to address.

Also many studies were reviewed based on Service Quality model given by Parsuraman et al. The use of this model in Private Health care Industry in India is very rare. Again the same model is not used for Private Health sector in the state of Gujarat, Which again makes this study different from others.

From the literature review on Health care sector, topics studied by various authors are, patients satisfaction, determining factors of satisfaction, health care management, various aspects of hospital management, use of quality control techniques by hospitals and its impact on performance, significance of quality control and use of Service Quality model in health care sector. Hence, it can be observed that service quality model has been successfully applied to hospitals services by various researchers.

In this thesis research is conducted to know service quality and patients satisfaction in selected Private Hospitals of Gujarat.
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92


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103


