Chapter VII

CONCLUSIONS AND SUGGESTIONS
INTRODUCTION
This chapter highlights the main findings and analytical conclusions that have been drawn from this study and presents some suggestions. The relevance of the findings has been discussed with reference to the practical needs of the hospital under study as well as the possible applicability to other comparable settings. The suggestions have also been given for two purposes: quality improvement of the hospital services and areas for further research in hospital service quality and marketing.

7.1: MAIN FINDINGS AND ANALYTICAL CONCLUSIONS
1. Service Quality Factors / Domains:
   Interpersonal or soft factors are considered more important than technical, clinical or hard factors of service quality. Out of the six factors that emerged from the factor analysis of the responses, four were related to the interpersonal domain: Empathy, Respect, Communication and Responsiveness. Tangibles did not emerge as important except for a reasonable degree of Cleanliness - there were no expectations of a pleasant ambience other than very practical aspects of cleanliness. The clinical factors were indirectly judged by means of the Credibility, image and reputation domain. This finding can be generalized to other similar settings and respondent groups. This study confirms other researches from various cultural settings and re-establishes healthcare as an intangible dominant service with high credence qualities followed by experience properties. It is not a "search" good that can be evaluated by means of tangible attributes.

2. Credibility:
The hospital has a consistently high rating of its credibility, diagnostic capability, and positive payoffs from its teaching and research affiliation. This finding emerges consistently regardless of the effects of some of the
variables like (high) perceived severity of illness, history of previous (private or public sector) hospitalization for the same health condition and (negative) clinical outcomes. Although there were mixed ratings for other factors, all the patients rated the hospital very high on credibility. This is a hospital specific finding. However, comparing this with other teaching hospitals can give clear pointers to market positioning of the hospital. This strength could also be leveraged for pricing decisions.

3. **Quality Gaps:**
The hospital is in general, unable to meet patients' expectations of empathy, communication and responsiveness. However, responsiveness and communication are perceived to be better if the patient knows a hospital employee. This finding could get repeated in other teaching public hospital settings that face similar conditions of high demand for service versus limited time and personnel resources. Further, the greater the perceived severity of illness, the lower was the rating of the hospital's services, especially of responsiveness to specific needs of such patients.

4. **Patient Involvement:**
Patients' Involvement has been seen to exert a very strong influence on quality perceptions as well as clinical outcome. Patients who take the initiative in participating in self-care, comply with instructions on treatment and diet regimens, communicate readily as well as actively seek information about their health, and display an attitude of help and cooperation with other patients and hospital employees have been classified as High Involvement group. This group has registered higher levels of performance perceptions of the hospital's services and recorded better clinical outcomes. This finding gives scope for more research in the conceptual as well as action domains. Involvement was found to be associated with education as well as payment for service, which need to be explored and confirmed.
5. **Service Purchasing behaviour - History of Previous Hospitalization:**

Whether the patients had previously sought treatment from private or government run hospitals for the same health problem, it made little difference to their expectations or hospital performance perceptions. Both private and public hospitals probably behave in a similar way when it comes to catering to patients' salient expectations in terms of the six domains identified by this study. This finding, although indirect, deserves merit and brings into question the quality of service rendered by private providers being perceived equal to that of this public hospital despite the prices being charged by the former.

6. **Service Quality Predictors:**

Out of the four predictors of hospital service quality - clinical outcome, patient involvement, hospital employee known to patient and length of hospital stay - involvement can be one of the influences on outcome, and length of hospital stay can help in patients getting to know the employees that are in direct and consistent contact with them. Familiarity with the location of various relevant departments and procedures of the hospital can help patients become more independent and thereby enhance their feeling of empowerment, leading to more active involvement in their own care. However, the variables are not collinear and can be regarded as four independent variables predicting service quality. This finding could be tested in other similar settings.

7. **Access:**

Access to special wards was constrained by extraordinary length of stay by obstetrics (fertility clinic) and orthopaedics patients, occupying the beds for a very long time and thereby denying others the facility. Inequity of access was further enhanced due to hospital employees getting priority for special ward admissions and other patients managing to get the facility because of
knowing an employee. This is a hospital specific finding that can be useful in planning future needs and facilities.

8. **Providers' Insight into Patients' Perceptions:**

Doctors had over-rated patients' expectations although they had little difference as far as the performance of the hospital were concerned. Unrealistically high judgement of expectations can lead to feelings of impossibility in determining the quality standards and in translating them into deliverables. This over-rating of expectations could result in the mindset that patients' expectations are not in the realm of what is practically achievable and therefore are impossible and ideal targets to work on.

9. **Organizational Culture:**

The organizational culture of the hospital was perceived to be functional hierarchical emphasizing order, authority, security and entitlement. The doctors felt that there was no recognition for superior performance or deterrent to inferior performance, very little autonomy to the institution as a whole, a consequent slowing down of decision making and resource constraints impeding creativity. The target culture was desired to be more customer and employee process-based and network based in order to enhance responsiveness to customer needs and to innovations in the external environment.

10. **Nurses' Task Perceptions:**

Nurses perceived that they were spending a disproportionately longer time in record keeping work rather than doing patient related tasks. This finding has to be seen in conjunction with the non-use of the computerization facility provided at the nursing station in every ward. Manual record entry at multiple points (transfers between general and special wards or two special ward categories) in separate registers for admission and discharge could be the cause of this malady.
7.2: **SUGGESTIONS**

Two sets of suggestions emerge from this study. The first set consists of suggestions to initiate and implement a quality improvement program with a service marketing orientation for the hospital taken up for this study. This includes both short-term and long-term programs that may be initiated by the hospital. The second set of suggestions is related to identification of areas for future research in hospital services marketing.

7.2.1: **Suggestions for Quality Improvement:**

1. **Soft Skills Training for Customer Contact Employees:**
   
   Training programs have to be designed for doctors and nurses on the soft skills of patient care highlighting the felt needs of patients in the areas of empathy, communication and responsiveness. The reality of resource constraints and effect of time pressure on the employees have to be addressed by a personnel needs assessment exercise in order to have workable patients to caregivers ratios.

   Training for support staff (security, sanitary and ward staff) on communication and general etiquette.

2. **Customer / Employee Focused Culture - Internal Marketing:**
   
   Training can provide only short-term gains and increase awareness about the felt needs for soft quality. The organizational support for active use of skills and attitudes obtained through training has to come from a culture change emphasizing more on employee focus for delivering better service quality. Internal marketing programs have to be designed that convey appreciation for better performance even if extrinsic rewards cannot be accommodated within the existing government-controlled terms of work. Commitment to quality has to be communicated through actions that recognize and reward quality efforts.
3. Equity of Access:
Additional resources for Special Wards have to be built up, followed by introduction of a quota for other patients vis-a-vis hospital employees and transparency in allotment by means of a daily report visibly exhibited on a Display Board as practiced in the Railway Reservation System.
Another issue to be addressed here is equity in responsiveness regardless of whether the patient knows a hospital employee. This aspect has to be taken up as a unique feature of a teaching government hospital where most of the services face a high demand that has to be met against constraints of resources and time.

4. Patient Involvement - Interactive Marketing:
Interventions have to be designed and tested to enhance patient involvement and participation in care. Highly involved patients can be motivated to evolve "patient circles". Currently, a few involved patients are being informally requested to assist wherever possible in the wards. A formal system of identifying them as a viable segment has to be set up. They can be treated as a reference group for diffusion of involvement as a useful behavioural factor in healthcare. Patients' contribution to 'Best Ward' schemes can be recognized by awarding 'Best Customer' points, as an informal motivator rather than in any extrinsic form. While other components of involvement may be inculcated through educational interventions, as far as maintaining personal and ward cleanliness is concerned (a component of high involvement behaviour) the expected behaviour has to be enforced as compulsory.

5. Policy on User Charges - Repositioning the Hospital:
The scope of the hospital's existing user charges has to be examined, widened and upwardly revised in the interest of better quality. Charges across the board can enhance involvement and deter undesirable behaviours. However, more rationalized (upward revision) pricing can
make cross-subsidization more effective. Concurrently, facilities have to attract paying clientele and communicate the positioning of the hospital as one offering superior diagnostic services - a major strength of this hospital. The current practice of providing all consulting and testing services free of charge to all outpatients has to be stopped and high-income patients have to be charged for these services. This study found an association between patient involvement and payment for services that can be further explored.

6. **Patient Dropout Analysis:**

A preliminary analysis of special ward admissions during this study revealed a need for looking into this problem. The root of this finding lies in analyzing the utilization pattern of the outpatient services that was beyond the scope of this study. An analysis of the outpatient records can bring out the extent of 'patient dropout' after using the outpatient services - especially those who are advised hospital admission. If it is found that potential paying clientele are dropping out, the reasons have to be identified. If access to a Special ward is the problem, it can be tackled to the extent possible as suggested earlier. If patients with an ability to pay are merely using the outpatient services because they are free, the hospital is needlessly extending its subsidized facilities to the wrong target market segment in addition to over-burdening its already scarce resources. If free outpatient services are being used only for diagnostic purposes, the hospital is losing out an attractive market segment to other players.

With all the infra-structural resources that have been provided due to its status as a premier and internationally acclaimed medical research and training institution, the training here is restricted to cater to only one class of customer - the underprivileged - with lower expectations and very wide 'zones of tolerance' for service performance. In the long run, the inadequate exposure and training to cater to a more demanding clientele
can give rise to a low quality spiral that can result in difficulty in attracting better employee and student talent.

7. **Hospital Information System:**

The full potential of the data that can be available with the Hospital Information System initiated in the hospital is not realized as data entry is not being done at all the levels (e.g. inpatient wards). Consequently, the data is dated or incomplete and therefore not usable. The computerization program does not seem to have been communicated to all the concerned employees. Nurses' perceptions about the time taken for record keeping can be directly attributed to the fact that they are manually entering all the inpatient data into registers and not using the computer provided at the Nursing Station in each ward. A training program on the advantages of computerization over the currently employed manual entry for inpatient records is an immediate need. Further, computer trained personnel from the Medical Records Department have to update the system by making the entries of admissions and discharges from the individual wards.

7.2.2: **Suggestions for Further Research**

1. **Consumer Involvement as a Construct:**

Consumer Involvement has been found to be an important input variable that influences hospital service quality perceptions. Moreover, the provider can evolve programs to influence involvement whereas little can be done to alter the demographic background of consumers. Thus, involvement is a useful and actionable variable as health care is a service that demands participation from the consumer. There are no specific standardized instruments to measure involvement. Therefore developing on the concept of "involvement" with cognitive (information processing), affective (motivation and locus of control) and behavioural (overt actions)
components and constructing an instrument for measurement can by itself become a topic for research.

2. Involvement - Satisfaction Path Analysis:
A path-analytical study tracing the sub-components of the Involvement construct leading to satisfaction can provide inputs necessary for designing programs to enhance involvement. Analyzing the effects of intervention alternatives designed to promote involvement can test and confirm this linkage.

3. Alternative Methodologies:
Questionnaire items for the Hospital Service Quality scale although subjected to evaluation by some patients and doctors, were developed from items and constructs reported in literature and alpha reliability was considered acceptable. Further validation using alternative research designs can lend robustness to scale construction.

4. Category Generalization and Comparison:
The study may be replicated in other comparable research settings. This could either strengthen generalization or provide rich data for comparison that could be useful in policy formation and quality benchmarking.

5. Comparison across Categories:
It has to be tested whether the Hospital Quality Domains or Factors would indeed differ for public versus private hospitals as conceptualized in literature. This study found no difference in perceptions of patients with differing history of previous hospitalization. Further confirmatory study is required to see whether the structural dimensions would influence quality perceptions.

CONCLUSION
This chapter thus concludes with a listing of the main findings and two sets of suggestions: 1) for quality program implementation, and 2) for further research.