Chapter I

INTRODUCTION
1.1: INTRODUCTION

Health care occupies a vital place in the social services sector and is essential for achieving sustainable human development. Hospitals are a very important part of any health system. The largest share of national health expenditures ranging between 60 to 80 percent, is for hospitals, regardless of the health status and income level of a country. Within the public hospital sector, the large and teaching hospitals are granted a higher proportion of the available financial and other health sector essentials in terms of human, physical and technological resources.

The core goals of health systems as prescribed by the World Health Organization are: ¹

- improving health status
- reducing health inequalities
- enhancing responsiveness to legitimate expectations
- increasing efficiency
- protecting individuals, families and communities from financial loss
- enhancing fairness in the financing and delivery of health care

1.1.1 Role of Public Hospitals

The demands placed on public hospitals and expectations from them are manifold. National health systems stress the role and importance of hospitals for an integrated approach to the promotive, preventive, curative and rehabilitative aspects of health care.² Peer review of the health care profession is recommended on seven aspects: curative care, preventive care, health education, management, training of other personnel, research, and teamwork and collaboration with other social development sectors.³

The role of hospitals is envisaged at three levels of functioning. Hospitals functioning at the first referral level (of any type and size including even large teaching hospitals) accept referrals from first contact level facilities
like Government Primary Health Centers or private general practitioners. In practice, the concept of first referral hospitals was generally associated with the smaller district hospitals in rural or urban settings. Second referral hospitals were seen as serving larger populations and providing all but the most complex kind of hospital services. Tertiary level hospitals offered highly specialized, high technology interventions for less frequent and very complicated conditions thus providing last referral care.¹

Large teaching hospitals act as a reference point for the national health system and have a special position of authority in influencing medical thinking. These hospitals may belong to the private sector or to the public sector.

1.1.2: Problems in Public Hospitals

Public hospitals are often overcrowded and resources are stretched between producing human resources needed for health and taking care of patients that cannot be looked after at other levels of the health system. The urban poor and a large share of the rural population are serviced by public hospitals at various levels and are referred to the teaching hospitals as they are equipped with a higher level of technology and manpower. While on the one hand hospital policies in the public sector are being implemented within the constraints of inevitably finite resources, yet on the other, they are operating in a dynamically changing, increasingly sophisticated and costly technological environment. "The shadows of healthcare delivery are becoming increasingly visible. They outline a future where healthcare providers will need to do increasingly more with increasingly less under very uncertain financial circumstances." (Halverson et al, 1997).²

"Healthcare provision faces a grim outlook. Budgetary pressures, set against an increasing elderly population, plus rising expectations and
technological advances, all point to increasing conflict for resources. Decision-making at community level, with patients, doctors, nurses and managers included, will be the most effective way of allocating scarce resources, and of exerting pressure for more." (Pritchard, 1995)  

1.1.3: Expectations of Funding Agencies

World bank supported projects have started addressing quality assurance issues explicitly and incorporating actions to improve the quality of health care. This development is more demand and supply driven as World Bank staff and client countries are increasingly aware of the benefits of continuously striving to improve the quality of services offered to populations. Benefits would include a more efficient use of current resources, a potential reduction in unit cost, better utilization of services offered, a more rational use of drugs, a customer orientation and beneficiary participation.  

Service quality falls when the required inputs (physical and human) are lacking, and when proper procedures are not used. Common symptoms in the public sector are a lack of essential drugs, inaccessible health facilities or absent staff, non-functioning vehicles and equipment, and dilapidated premises. Where these symptoms occur, health outcomes suffer. People's perceptions of the fairness and responsiveness of government also suffer. Comparable difficulties abound in the private sector. Private providers, however, have often ensured that their office locations and opening times are convenient for people.  

Hospital accreditation programs granting official or public recognition and approval of an institution as having particular quality or performance began on a voluntary basis in the United States in the mid-seventies. Standard setting as a tool for Quality Assurance has been used by the private sector organizations for accreditation or certification, as well as by governmental units for licensing requirements. On-site surveys of health care
organizations including hospitals, home care agencies, mental health programs, nursing homes, primary care centers and laboratories are performed to compare actual performance with standards. Citizens' Charters or Patient's Charters introduced by governments is another attempt to ensure standardization and compliance to quality norms drawn up from the patient's perspective.

Few ministries of health or public providers use mechanisms for assessing people's preferences or satisfaction with the way health services are provided. Such unresponsiveness has been part of the environment in which private provision has flourished. Greater accountability by the public sector requires much more concern with the way health workers treat people, both clinically and socially.  

Given this background, evolving a methodology to assess the performance of public hospitals as perceived by their clientele assumes importance. A study focussed on the beneficiaries of a public hospital as part of the public health care system could bring out strengths and weaknesses of the system and provide direction for changes in the service delivery process.

1.1.4: Health Policy Imperatives

"Global experience has shown that the quality of public health services, as reflected in the attainment of improved public health indices, is closely linked to the quantum and quality of investment through public funding in the primary health sector. Statistics show clearly that the standards of health are more a function of accurate targeting of expenditure on the decentralized primary sector (as observed in China and Sri Lanka), than a function of the aggregate health expenditure.

Therefore, the NHP-2001, while committing additional aggregate financial resources, places strong reliance on the strengthening of the primary health structure with which to attain improved public health outcomes on an equitable basis. Further, it also recognizes the practical need for levying
reasonable user-charges for certain secondary and tertiary public health care services, for those who can afford to pay.  

The following questions need to be considered: How can the limits to government involvement and government finance be recognized, and how can choices be made that best achieve the right balance between systemic goals while recognizing budgetary and other limits? What incentives for providers of care will constrain cost escalation while motivating compassionate service of high quality? Independently of sources of finance, what are reasonable roles for private and public providers of care to play? How can research and development to underpin continued health improvement globally be sustained in a context where most health finance is national? Finally, and most important, what is the role of government in financing health services?

The values of the WHO lead away from a form of universalism that has governments attempting to provide and finance everything for everybody. This classical universalism fails to recognize both resource limits and the limits of government.

The WHO findings also lead away from market-oriented approaches that ration health services according to the ability to pay. Not only do market-oriented approaches to finance lead to intolerable inequity with respect to a fundamental human right, but theory and evidence indicate them to be inefficient as well. Market mechanisms have enormous utility in many sectors and have underpinned rapid economic growth for over a century in Europe and elsewhere. But health is an important component of national welfare and requires a combination of universal entitlement and tight control over expenditure.

A "new universalism" that recognizes governments' limits but retains government responsibility for the leadership and finance of health systems has to emerge. The new universalism welcomes diversity, and, subject to
appropriate guidelines, competition in the provision of services. At the same time it recognizes that if services are to be provided for all then not all services can be provided. The most cost-effective services in a given setting should be provided first.  

To maximize the efficiency and equity gains, and create “win-win” situations in poorer countries, universal coverage with some key design features has been envisaged:

- Membership is defined to include the entire population i.e. it is compulsory. Whether this is by citizenship or residence, the purpose is to ensure that the population covered is defined inclusively.

- Universal coverage means coverage for all, not coverage of everything. The prepayment system, financed by government, corporations and better-off individuals, will reflect a country’s overall level of economic development. It will be a limited fund, not able to pay for all of those services that the population – and the health workforce – would like to see provided at no charge. Lower priority services, which will vary from one country to another, will only be available for payment. A benefit package has to be clearly defined in the light of the resources available and the cost of top priority health interventions. An assessment of the services and inputs for which individuals are able and willing to pay out of their own pockets and the political feasibility of various choices is also to be considered.

- The patient does not make the provider payment at the time he or she uses the health service. Health care always has to be paid for. But the way it is paid for makes a major difference to who gets care and to overall levels of health. Out-of-pocket payments penalize the cash poor: those who work outside the cash economy, or who have only seasonal or occasional cash income, or who are unemployed. Heavy reliance on out-of-pocket payment sets the wrong incentives for both users and
providers, and results in an inequitable financing burden and barriers to access for the poorest. Prepayment allows a wide range of incentive-setting methods for the efficient purchasing of services.

- Services may be offered by providers of all types provided that health practices and health facilities meet certain quality standards and that they are subject to similar levels of managerial flexibility, their ownership status should not matter. A stronger purchaser setting standard rates of remuneration and enforcing a common set of quality and utilization regulations will enable the most efficient provider of services to flourish. Such arrangements will allow the very large numbers of private providers, who are essentially the first points of contact with the health system in many low-income countries, to be brought within a structured but pluralistic health care system. While benefiting from its resources, they can also be subject to sanction and regulation by professional and public bodies.

1.1.5: The Indian Scene - Quality Standards

In India, it can be seen that issues of health care quality are as yet in a very nascent stage. State intervention in regulating or prescribing quality is minimal. The few regulations that exist – the Nursing Home Registration Acts of Delhi and Bombay, Drugs and Magic Remedies Act, Pharmacy Act and the Consumer Protection Act (C.P.A.) have been ineffective. Medical Councils that are required to be set up at every state, are statutory bodies that set the standards of medical practice, discipline the profession, monitor their activities and check any malpractice. The council issues a certificate of registration that requires periodical renewal.

The Nursing Home Registration Acts provide for registration and inspection of hospitals and nursing homes. Information on qualification of staff, adequacy of staff, equipment, accommodation facilities and space, and drainage and sanitary conditions is scrutinized before granting registration.
There is also the provision for periodic inspection and renewal of registration.

The word "adequate" is used coupled with the absence of prescribed minimum guidelines for space, sanitary conditions, personnel, and standardization of fees to be charged, etc., to be followed by the hospital and nursing home authorities. Moreover, the medical councils have failed to resist the pressure from politicians and have given permission for starting of private medical colleges that are substandard, understaffed, and do not meet the prescribed minimum facilities like having their own hospitals. (Nandraj, S. 1994)  

In the large and inadequately regulated private sector of low and middle income countries, health workers are often unqualified and diagnostic and prescribing practices are poor or even hazardous. Private sector treatment of tuberculosis, for example, often involves profitable but useless intervention while failing to achieve the high cure rates that have been attained in public facilities.  

The Indian Medical Council Act, which prescribes a code of conduct for practitioners, does not contain adequate provisions regarding professional service quality in the form of negligence or deficiency in service (Joshi, 1997). The IMC Act does not provide for the rights of the patient. No attempt has been made to develop an inventory of standard norms for general and approved practice. There is a lack of a database on providers and their practice, lack of adequate standards for comparison of performance, lack of a database on risk factors of diseases, diagnostics and procedures and lack of an orientation program for doctors on quality as well as regulation. (Bhat, 1996)  

In India the private health sector hospitals differ very widely. On the one hand, there are the huge corporate hospitals and the majority of hospitals on the other are those having 10 to 30 beds whereas public sector
hospitals provide a relatively uniform base in terms of size and facilities. Indian researchers in management have concentrated on the corporate hospital sector as private providers can perhaps be persuaded to implement marketing programs more easily as long as they are profitable. Studying the public sector hospital from the consumer's perspective has largely been neglected.

An estimated 70 percent of hospitals and 50 percent of hospital beds are in the private sector (Bhat, 1996). Thus, about 50 percent of total hospital beds are being serviced by just 30 percent of hospitals that are in the public sector. Each public sector hospital therefore caters to a much larger volume of patients as compared to any hospital in the private sector.

1.2: STATEMENT OF THE PROBLEM

This study focuses on the beneficiaries of a public hospital as part of the public health care system and evolves a methodology to assess performance as perceived by the clientele. It could bring out the strengths and weaknesses and give direction for change in the service delivery process.

1.2.1: WHY STUDY THE INDIAN PUBLIC SECTOR HOSPITAL?

1. Basis for Comparison:

In India the contrasts in the private health sector hospitals is vast. While there are the huge corporate hospitals on the one hand, the majority of hospitals on the other are those having 10 to 30 beds. In rural areas, clinics with one or two beds for providing indoor care are also classified as hospitals. At the higher end we have the corporate hospitals and trust hospitals and at the lower end in terms of size and facilities, there are the clinics with an average of ten beds. Any study made of this sector will have to restrict itself specifically to each of these categories with very limited
possibility of generalization and actionable outcomes. Public sector hospitals provide a relatively uniform base in terms of size and facilities lending themselves to better generalization and focus on improvement.

2. **Need for services marketing approach:**

Many Indian researchers in management have concentrated on the corporate hospital sector as it probably more strongly resembles a business firm and offers a degree of comfort in the use of terms like customer focus, marketing programs, and competitive strategies for bringing a certain amount of "business". "Medical entrepreneurs run most private hospitals. The cycle in health care does not start with a trained medical person and a sick person in search of each other, but with an investor in the share market in search of a profitable investment. The availability of newer medical technology and a market in medical care enhance the attractiveness of the investment." (Phadke, 1993 cited in Nandraj, 1994) 

Thus the private sector can be persuaded to implement marketing programs more easily as long as they are profitable. Studying the public sector hospital can be conceptually more demanding and can meet the need for a different approach to services marketing with its basis on cost sharing and responsible use of resources.

3. **Service Volume:**

In India, during 1974, 16 percent of the hospitals and 21.5 percent of the hospital beds were in the private sector and the rest were in the public sector. This proportion had increased by 1990 to 57.95 percent of the hospitals and 29.12 percent of hospital beds in the private sector (Nandraj, 1994). An estimated 70 percent of hospitals and 50 percent of hospital beds are in the private sector (Bhat, 1996). This amounts to about 50 percent of hospital beds still being serviced by the public sector. The sheer magnitude of the customer base demands a study of the perception of the beneficiaries of public hospitals.
4. **Responsibility to treat:**

The majority of private hospitals and nursing homes across the country generally refer patients who develop complications to public hospitals so that they are not liable for cases of death. Most of these hospitals refuse admission to accident cases and those involving medico legal work, even when patients are in a very serious condition. Many institutions refuse admission to patients unless a certain amount of money is paid in advance. In contrast, public hospitals, in most cases do not refuse admission to seriously ill cases if they have the facilities. In public hospitals, one can still demand services while private hospitals can turn patients away at their will. (Nandraj, 1994) 

A study of the public hospital from a services marketing perspective will help not only in getting the providers to understand their clientele, but also in getting the customers to participate more responsibly in their own care.

5. **Citizens’ Charters:**

Many of the public sector hospitals have developed their individual versions of a Citizens' Charter. This is the case especially with the larger teaching hospitals. A public sector tertiary care hospital in New Delhi has an ongoing system for eliciting patients' opinions on hospital service in special wards with the help of exit pro-formas designed and implemented twenty years ago. But they observe that it has become a ritual instead of a tool for improving operational efficiency. (Vij and Sharma, 2000) 

A formal study of customer expectations will help bring a sharper focus and specificity to the quality specifications in order to make them more actionable and operational.

6. **Need for Re-positioning:**

The resource crunch will force a rethink on the economic model for achieving the social goal of health for all. There will be an increased need to scale down subsidies to non-basic health facilities and recover costs
from those who are in a position to pay. User charges would give a sound financial foundation for the production of health services and reduce the vulnerability of service delivery to the availability of public finances. The Tenth Five Year Plan Document recognizes the commitment to provide essential primary health care, emergency life saving services, services under the National Disease Control Programs and the National Family Welfare Program free of cost to individuals based on their needs and not on their ability to pay. At the same time, suitable strategies will have to be evolved, tested and implemented for levying, collecting and utilizing funds obtained for health care services from people above poverty line. Rationalizing the price structure of public health services would also ensure a better model of cross-subsidization and sharing of burden. For achieving these ends, there has to be an attempt to attract a larger proportion of paying clientele to public hospitals. A study of the strengths and weaknesses of a public hospital from the customers' viewpoint would help in repositioning the hospital for a higher socioeconomic class of consumers. As a necessary step to the repositioning effort, the organizational culture of the hospital would have to emphasize on customer orientation. Thus, a study of quality in such a setting could lead to a self-reinforcing quality spiral built on a win-win model that could benefit the customer and the provider.

1.2.2: Expected Contributions of the Study

Service quality predictors: At the conceptual level this study could be useful in formulating a model of predictors of service quality in the public health care delivery set-up. This would further help in service process design for better quality with a customer-focussed approach.

Quality program implementation: At the implementation level, this study could result in the design and incorporation of newer ways of providing the
service, re-orienting employees' approach to the service through training programs and organizational support. The study results could provide the background necessary for an effective Internal Marketing program. For External Marketing, attention could be paid to de-marketing or re-marketing aspects of the service offer as well as delivery to the customers, and re-positioning to attract other profitable customer segments. This project could serve as an initial step to introduce more transparency into the public health care delivery system.

**Patient involvement:** Customers could be educated to use the service more responsibly by identifying potential areas for Interactive Marketing. This is imperative in order to offset to the extent possible, the effects of providing the services free of cost as well as wastage of facilities by customers. Programs to increase patient involvement in health care can be designed.

**Policy on user charges:** At the policy level, this study can provide some of the background necessary for making more realistic pricing recommendations.

**SWOT Analysis:** Preliminary information could be obtained for an organizational Strengths-Weaknesses-Opportunities-Threats Analysis for the hospital services.

### 1.3: SCOPE OF THE STUDY

- The study uncovers the perceptions of Inpatients who have been admitted to the hospital through both Outpatient and Casualty / Emergency Service Departments. The minimum length of stay for inclusion in the study sample is more than seven days. Among the hospital employees, Doctors of clinical service departments and Nurses have been considered as the key informants for obtaining providers' perceptions.
This study does not directly obtain the patients' perceptions of the Outpatient services as studies assessing the quantum and quality of time spent with the patients have already been done earlier by the Department of Preventive and Social Medicine of the hospital. Moreover, given the very large number of patients serviced, and the time and resource constraints, it is not possible for a single researcher to study a representative sample of outpatients. Further, being a government hospital, all cases have to be seen and the "refusal to treat" option cannot be used in any form. Hence, little can be done to alter the situation in terms of balancing the workload, and the resources available for completion.

This study also does not include quality assessment for clinical processes / outcomes and utilization reviews for resources. Such analyses are already being done at the monthly Medical Care Review meetings and programs for Rational Drug / Investigations use respectively. Medical Care reviews address clinical morbidity measures (re-admissions, infection rates, critical care review, etc.) and mortality measures (death statistics) with a view to analyzing and improving the quality of clinical care.

The study however, indirectly measures outpatient perceptions also as all inpatients must have been either outpatients or emergency cases. In the emergency cases, most patients may not be in a position to recall their experience and proxies (key relatives or attendants) have to be used as respondents. This study obtains the views of direct patients only and not proxies.
1.4: OBJECTIVES

The following were the study objectives:

1. To identify the factors or domains that describe inpatient service quality.
2. To study the relationship between patients' expectations and perceptions of hospital service performance.
3. To identify and analyze the service quality gaps.
4. To compare perceptions of patients and doctors.
5. To identify the determinants or predictors of inpatient service quality.
6. To study the perceptions of main contact employees: doctors/nurses.
7. To make suggestions based on the findings of the study.

1.5: HYPOTHESES

The following twelve sets of research hypotheses were proposed and tested.

1. There is no difference between patients' expectations and perceptions of hospital performance.
2. There is no difference between the expectations (or hospital performance perceptions) of male and female patients.
3. There is no difference between the expectations (or hospital performance perceptions) of patients with differing education levels.
4. There is no difference between the expectations (or hospital performance perceptions) of patients from urban and rural areas.
5. There is no difference between the expectations (or hospital performance perceptions) of patients with differing severity of illness.
6. There is no difference between the expectations (or hospital performance perceptions) of patients who show differing levels of involvement in their own care.
7. There is no difference between the expectations (or hospital performance perceptions) of patients based on the history of previous hospitalization for the same health condition.
8. There is no difference between the expectations (or hospital performance perceptions) of patients who pay and those who avail the services free.

9. There is no difference between the expectations (or hospital performance perceptions) of patients who knew and those who did not know any hospital employee.

10. There is no difference between the expectations (or hospital performance perceptions) of patients based on whether all facilities are provided free of charge or some priced.

11. There is no difference between the hospital performance perceptions of patients with differing clinical outcomes.

12. There is no difference between the expectations (or hospital performance perceptions) of patients and doctors' insights into perceptions of patients.

1.6: RESEARCH METHODOLOGY

1.6.1: Location and Study Area Definition:
This study was conducted in the Jawaharlal Institute of Postgraduate Medical Education and Research (JIPMER) Hospital, a tertiary care public teaching hospital and medical research institute operated directly under the Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India.

This is a cross-sectional, analytical research into the determinants of inpatient service quality perceptions of the external and internal customers of a teaching public hospital. This study was conducted using the survey method. The external customers were the inpatients and internal customers were the doctors of clinical departments and nurses of the hospital.
The study was carried out in two parts:

PART I: Statistical study conducted in two phases to find out the determinants of hospital service quality from the patients' and physicians' perspective. Phase 1 for development and standardization of the research instrument and Phase 2 for study of patients' perceptions.

PART II: Descriptive exploratory study to identify some of the organizational factors contributing to performance of the principal contact employees: physicians and nurses.

Figure 1.6a: Study Area Definition

<table>
<thead>
<tr>
<th>Outpatients (OP)</th>
<th>Inpatients (IP)</th>
<th>Casualty / Emergency (C / E)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IP LHS &gt; 7 days</td>
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</table>

Support Staff  Doctors  Nurses  Lab. Technicians

Note: LHS denotes Length of Hospital Stay

Source: Original - constructed for this study.

1.6.2: Data and Sources:
The study was based principally on primary data collected from the participants. Secondary sources were used mainly as background material for choice of respondents.
Secondary Data Sources:
Secondary data was taken from the hospital records. Details of in-patient statistics, Patient Case Records, Ward Registers, daily Discharge list and Summaries, were some of the records scrutinized for collecting the background data for conducting the study. Further, as part of the service process, the nature and duration of contact of the inpatients with various types and levels of hospital employees, was ascertained after discussions with contact employees drawn from the Medical Records Department, Laboratory Technicians, nursing personnel and doctors.

Primary Data Sources:
Primary data was collected from the external customers of the hospital i.e., in-patients, and the internal customers or the main contact employees, viz., the consultant doctors and nursing personnel. The study was restricted to inpatients for practical reasons of accessibility to patients who have already experienced many of the service components of the hospital. Doctors and nursing personnel were found to be the primary care givers or contact employees as far as inpatients were concerned. The other contact employees like the technicians, cleaning staff, ward staff, and administrative staff had limited interaction with patients as part of the service process.

1.6.3: Sampling Description:
For sampling of inpatients, a proportional stratified sampling strategy was used to obtain a sampling frame from the target population whereby the number of subjects obtained from each stratum was directly proportional to that stratum's relative population size.
Part I of the study was conducted by surveying 230 inpatients and 30 doctors from the clinical service departments included for the study. Part II of the study included 25 doctors and 70 nursing personnel. The details of
bases of stratification, inclusion and exclusion criteria for selection of respondents are presented in Chapter IV on Methodological Framework.

1.6.4: *Period of the Study*

The study of patients' perceptions (Part I) was conducted over a period of fourteen months from July 1999 to August 2000. Phase 1 was completed in July-September '99 and Phase 2 was conducted during the period November 99 - August 2000. Part II i.e., survey of nursing personnel was conducted during the period November 1999 to June 2000.

1.6.5: *Data Analysis and Statistical Tools:*

Factor analysis, Multiple regression and correlation analysis was used to arrive at the predictors of service quality. Percentages, measures of central tendency and dispersion, the two-tailed t-tests for paired data and for independent samples and one-way ANOVA were used for testing of hypotheses. The standard package SPSS Version 7.5 was used for the statistical analysis. Depth interview findings were analyzed for obtaining the qualitative insights. Descriptive analysis using statistical measures like arithmetic mean, geometric mean, standard deviation, and percentages were also used and the results are presented in the form of graphs and tables.

1.7: **OPERATIONAL DEFINITIONS**

External Customers: Inpatients of the hospital

Internal Customers: Doctors of Clinical Service Depts. and Nursing personnel of the hospital

Doctors: Refer only to Asst. Professors, Associate Professors, Professors and Director Professors. (Medical Officers and Senior/Junior Resident Doctors, not included).
Service Quality score: Sum of the components of quality derived from the study

Service Quality Dimensions / Factors / Domains

Service Quality Determinants / Predictors

Expectations: Subjective service level that the patients believe a hospital ought to deliver

Performance / Perceptions:

Perceived Severity of Illness: Patients' subjective assessment of intensity and impact of their illness on their day-to-day life

Patient Involvement: Researcher's assessment of degree of patient's participation in care

Clinical Outcomes: Doctors' clinical assessment of patient's health status at discharge such as cured, relieved, status quo or worse

Length of Hospital Stay (LHS): Number of days an inpatient has stayed in the hospital

1.8: LIMITATIONS OF THE STUDY

This study is subject to the following potential limitations:

- This study has all the strengths as well as the weaknesses of the Case Study research design. The strength lies in the depth, contextual usefulness and quality of data that could be obtained. The limitation is in the extent of generalization that is possible as the data is context specific. However, other researchers in hospital quality measurement report the same experience, as this service is highly experiential and involves greater participation by the consumer. In fact, the extant literature in this area cautions against generalized approaches.
The respondents in the patient sample were mostly illiterate and the researcher's understanding of their views could differ from their exact perceptions while transcribing the data to fit into the Likert type scale.

Standardized questionnaires limit the response options of participants. This limitation has been offset to an extent by taking into consideration the qualitative insights and data obtained from depth interviews.

Interviews being the only usable option in this setting, the sample size was limited by time constraints of the researcher as well as the respondents. The study had to be conducted without disturbance to the routine functioning of the hospital and with consideration for the fatigue of the patients due to their health condition.

Quality perceptions of patients may suffer from the "gratitude" factor if they have been cured or relieved of discomfort and the reverse may be true if they have had negative clinical outcomes. This is an inherent limitation of measuring quality in the hospital setting itself.

Exit interviews or measuring perceptions at discharge are criticized for being "transaction specific" or applicable to the particular hospital stay experience. Using stratified sampling and ensuring representativeness of respondents has minimized this problem. Patients have been drawn from a wide cross section of service departments that can offer potentially dissimilar experiences in the hospital.

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.
1.9: BRIEF REVIEW OF LITERATURE

This section provides an overview of the progression of steps that have been taken for assuring customer focused quality to consumers of healthcare and hospital services. Three distinct types of programs were identified in literature: a) Accreditation Programs following Standard Setting Practices, b) Citizens' Charters or Patients' Charters, and c) Patient Satisfaction Studies.

The emerging consensus in developed countries is on four key issues:23

- quality of care is not a given;
- there should be full public accountability for outcomes of care;
- accountability requires measurement of the quality of care provided to populations of patients; and
- public policies should promote continuous improvement of quality of care.

Standard Setting as a tool for Quality Assurance has been used by the private sector organizations for accreditation or certification, as well as by governmental units for licensing requirements. On-site surveys of health care organizations including hospitals, home care agencies, mental health programs, nursing homes, primary care centers and laboratories are performed to compare actual performance with standards.

As there was no sufficient data to determine standards for various medical procedures, quality improvement was seen as a way of establishing best practices - the optimal way of providing care. (Parker and Vitelli)24

Current trends in the United States are towards supplementing standards with performance indicators as part of the Clinton Administration proposals for health care reform. Report Cards of performance including preventive measures, early detection measures and outcome measures have been proposed.
In the UK, the need for quality assurance and consumer satisfaction got its impetus with the publication of the Griffiths report in 1983, questioning the lack of any form of quality audit in the National Health Service (NHS). This was followed by the white paper brought out by the Department of Health titled, "Working for Patients" (1989) recommending compulsory medical audit of diagnostic and therapeutic procedures, resource use, resulting outcome and quality of life for the patient. (cited in Feeney & Zairi, 1996)²⁵

The Australian Commonwealth Government sees its key role in "developing national performance measures to assess outcomes and quality, and to publish comparative data, and obtaining consumer feedback so that hospitals and healthcare professionals will be better able to address consumers' concerns. An assessment of performance in the areas of communication, respect, involvement in decision making, informed consent, privacy and access to interpreters could then be reported to consumers in a 'hospital score card'." (Stephen Duckett, 1996)²⁶

1.9.1: Hospital Accreditation Programs

Hospital accreditation programs grant official or public recognition and approval of an institution as having particular quality or performance. In the mid-seventies, the JCAHO – the Joint Commission on the Accreditation of Healthcare Organizations began on a voluntary basis in the United States. It was constituted for performing a quality review on clinical performance measures and outcomes adjusted for severity of patient illness. The Joint Commission is the largest of several private non-profit organizations that set standards and conduct surveys of organizations to identify performance gaps and stimulate improvement. "Accreditation was the first step in the evolution of some uniform and general standards for health care delivery" (Pickering, 1997).²⁷

The Korean Hospital Standardization Program 1980, Shanghai Hospital Grade Appraisal Committee of the China Health Bureau 1989, Medical
Accreditation and Audit Unit in Singapore 1991 and the Hospital Function Evaluation Program of Japan 1996 are in place to monitor quality. Korea has evolved from its initial stage of Hospital Standardization on the basis of manpower, facilities and organizational hierarchy. The Hospital Performance Evaluation Program, 1995 in Korea has been designed with more outcomes and patient oriented assessment indicators and to induce voluntary quality activities in hospitals. (Man Chung Han, 1997)  

1.9.2: Patients' Charters / Citizens' Charters

Patient's Charters introduced by governments is another attempt to ensure standardization and compliance to quality norms drawn up from the patient's perspective.

The term customer has the connotation of an individual where rights are concerned while consumer suggests that the individual is part of a group of users who can act together to safeguard rights. The following seven principles relate to consumers: access, choice, information, redress, safety, value for money and equity, but argues that their applicability in health may be limited, which results in the ability of consumers in the health system to act independently being restricted as well. (Carr-Hill, 1992)  

Patients' charters are an attempt to lay down the manner in which to “treat those who use health services as consumers within a market based and people centred system”. The use of the word patients underrates the status of the individual, as it implicitly creates a hierarchy. The patient should be defined as a consumer, a rationale that originates from the emphasis on the market mechanism. (Owens and Batchelor, 1996)  

The term consumer dignifies the professional/patient relationship in a way that the traditional term patient with its association of powerlessness against the medical establishment does not. Using the word client,
customer or service user similarly moves away from the idea of the user of medical services being passive and dependent. (Sitzia and Wood, 1997) 31

The United States Consumer Bill of Rights and Responsibilities, 1997, prescribes the role of healthcare organizations.32

In India, there is no formal participation of the government in the drafting of or commitment to a Citizens' Charter. Some of the public sector hospitals have developed their individual versions of a Citizens' Charter. This is the case especially with the larger teaching hospitals.

"A public sector tertiary care hospital in New Delhi also has an ongoing system for eliciting patients' opinions on hospital service in special wards more as a ritual instead of a tool for improving operational efficiency." (Vij and Sharma, 2000) 33

The following table presents a summary of Consumer Rights and Responsibilities extracted from the Patients' / Citizens' Charters of some Western and Asian countries34 - 38.

While many of the rights and responsibilities are common for all the countries, some are typical of Asian cultures. The language used and the wording of the Charters suggests that the provider - patient dyadic relationship proclaims more equality in the West, while in Asian countries, the patient appears to need more protection against exploitation.

Further, the socio-economic environment has made it necessary for Asian countries to include 'avoiding wastage and misuse of healthcare facilities' and 'acceptance of all preventive measures sanctioned by law' among the responsibilities of the patient.

In countries which have 'managed healthcare' programs and compulsory medical insurance schemes (the US for instance), Choice of Provider is restricted by the choice of health plan. The Charter provides for choice of health plan and is seen as restrictive by many critics.
Table 1.9: PATIENTS' CHARTERS: RIGHTS AND RESPONSIBILITIES

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Information Disclosure</td>
<td>X</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>Choice of Provider</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Access to (Emergency) Services</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Participation in Treatment Decision</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Second Medical Opinion</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Non-discrimination</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Respect for Privacy &amp; Dignity</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Confidentiality of Records</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Respect for Religious &amp; Cultural Beliefs</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Complaint / Appeal Mechanisms</td>
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<td>X</td>
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<td>X</td>
<td>X</td>
</tr>
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<td>Waiting Time Specifications Disclosure</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Access to Info. on Quality Standards</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Research/Training participation Choice</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Health Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Refusal of Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Chaperon during physical examination</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Info identity/ professional status of caregiver</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Company of Parent/Guardian for Child</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Participation &amp; Representation</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Charter published in Community Languages</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>CONSUMER RESPONSIBILITIES</th>
<th>US</th>
<th>UK</th>
<th>Aust</th>
<th>HnKong</th>
<th>Malay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximize Healthy Habits</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Involvement in Healthcare decisions</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Compliance with Treatment Plans</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Disclosure of Relevant Information</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Use internal complaint/appeal process</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Avoid knowingly spreading Disease</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Recognize Risks/Limits of Healthcare</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Understand provider's obligation to other patients  
Know Healthcare Plan coverage/ options  
Respect other Patients/Health Workers  
Meeting Financial Obligations  
Abide Admin./ Operational Procedures  
Report Wrongdoing / Fraud  
Avoid wastage/misuse Med. Resources  
Avoid asking for incorrect Certificates, Information & Receipts  
Accept Preventive measures by Law

Sources: Compiled from Patients' Charters

1.9.3: Patient Satisfaction Studies:
Quality of care can cover a wide spectrum. Structural quality can be defined as relating to dimensions such as continuity of care, costs, accommodation and accessibility while process quality involves the dimensions of courtesy, information, autonomy and competence. (Van Campen et al, 1998)

Internal checks on quality are not evident to patients. Doctors hold morbidity and mortality meetings to review care, diagnosis and clinical management skills. Laboratory equipment is calibrated to ensure performance. But patients tend to make their judgements based on the communication skills of the staff and the empathy shown by them. (Tomes and Chee Peng Ng, 1995)

There are eight dimensions: the art of care, technical quality of care, accessibility or convenience, finances, physical environment, availability, continuity, and efficacy or outcomes of care. These were reordered into
four factors: physician conduct, availability of services, continuity / convenience, and cost. (Ware et al (1975, 1978) cited in Lewis, 1994) 41

Providers must learn how to communicate the quality of their service if they are to compete. A study conducted by the Voluntary Hospitals of America (VHA) surveyed 4,000 consumers, 1,600 physicians and 1,600 employers. Widely varying criteria were identified as the key elements of high quality hospitals. Patients cited caring attitude of employees (52%) followed by a highly qualified medical staff (38%) as the most important criteria of quality. Advanced technological services and wide range of services were cited by 20% of the consumer respondents. Physicians attached significant importance to technology, facilities, and the quality of the medical and support services. Teaching and research functions were also considered as important to quality. (Nelson and Goldstein, 1989) 42

A study of patient satisfaction in a hospital in Kuwait used seven dimensions of hospital services: physician care, nursing care, housekeeping, hospital environment and facilities, admission process, radiology services and food services. (Guirguis, Mokhtar, -al-Torkey and Khalaf, 1992) 43

A four-year research effort in a study of over 50,000 patients from over 300 US hospitals representing every US census region developed separate questionnaires, called Quality of Care Monitors, for inpatients and outpatients. They included eight components for measuring inpatient care and seven components for outpatient care. For inpatient care they considered Physician Care, Nursing Care, Medical Outcome, Courtesy, Food Service, Comfort and Cleanliness, Admissions / Billing, and Religious Care. For outpatient care Physician Care, Nursing Care, Medical Outcome, Facility Characteristics, Waiting Time, Testing Services, and Registration Process were included. (Carey and Seibert, 1993) 44
Five components make up service quality: physicians, nurses, support staff, outcomes and structure. Among the fourteen dimensions under these five components, their additional contribution was the effect of physicians’ antithetical performance, and perceived physical as well as emotional cure on satisfaction. Negative emotional evaluations can undermine even the best clinical quality. (Zifko-Baliga and Krampf, 1997) 45

In general, researchers have used in-depth interviews and / or focus groups of patients and of physicians to arrive at criteria considered in quality evaluation. These criteria have been classified according to the structure / process / outcome framework and reduced to discrete items by removing redundancies. The items have been grouped under physician care, nursing care, support staff, outcomes and structure evaluation (amenities, billing procedures, etc.). The studies present a range of differing criteria and dimensions on the basis of:

(a) **type of service used** – inpatient / outpatient, emergency care
(b) **type of illness and intervention** – surgical, plastic surgery, radiotherapy, palliative care, physiotherapy, pharmacological, psychiatric, terminal illness, pediatric care, etc., and
(c) **type of customer** – ethnic or patients with culture-specific needs, elderly patients, key attendants or relatives, children, physicians, and funding agencies.
This thesis entitled "Determinants of Service Quality of a Teaching Government Hospital in South India: A Services Marketing Perspective" has been presented in seven chapters. The organization and brief contents of the chapters is as follows:

Chapter I titled "Introduction", presents an overview of the topic, statement of the problem, scope, objectives, hypotheses and methodology of the study, operational definitions of the terms used, the study limitations and a brief review of literature.

Chapter II titled "Background and Study Setting", presents a note on the choice of organizational setting where the study was conducted.

Chapter III titled "Theoretical and Conceptual Framework" details the conceptual foundations as contained in the literature on Services Marketing with specific reference to the healthcare and public hospitals sector.

Chapter IV titled "Methodological Design and Framework" brings out the nuances involved in the design and execution of such a study including the preparation of the research instruments and discusses the pros and cons of the various methodological issues that can influence the study.

Chapter V is presented in two parts. "Findings Part I: Customers' / Patients' Perceptions" gives the findings pertaining to Part I of the study that deals with the perceptions of patients, identification of factors / domains of hospital service quality, and determinants / predictors of hospital service quality. "Findings Part II: Providers' Perceptions" presents the results of the study of the Organizational Context in terms of Culture and Role Efficacy Perceptions of main contact employees i.e., doctors and nurses.

Chapter VI titled "Discussion and SWOT Analysis" provides the interpretations of the findings, linkage between individual findings, and a preliminary SWOT analysis of the hospital under study.

Chapter VII titled "Conclusions and Suggestions" gives a brief summary of main conclusions and suggestions based on the study results.
The "Select Bibliography" section lists mainly the Books, Reports and Journal Articles that have been referred to in addition to those mentioned as References under each chapter of the thesis.

The "Appendix" contains the questionnaires constructed for the study, the detailed tables for t-tests and ANOVA, factor analysis, reliability analysis, multiple regression, etc. as the summary of the statistical output tables have been presented in the body of the thesis.

REFERENCES


   Notes: One of the earliest initiatives to apply quality improvement techniques to health care in the US was the National Demonstration Project on Quality Improvement in Health Care (NSP), a 1987 joint venture of 21 health care organizations, funded by the John A. Hartford Foundation and hosted by the Harvard Community Health Plan.


32. United States Consumer Bill of Rights and Responsibilities, 1997
   Notes: The United States Consumer Bill of Rights and Responsibilities, 1997, prescribes the role of healthcare organizations in Consumer Rights, Protections and Responsibilities; Quality Measurement; Creating a Quality Improvement Environment; and Roles and Responsibilities of Public and Private Purchasers and Quality Oversight Organizations. Although issues of quality in healthcare have been addressed much earlier in the US, the Bill initiated during President Clinton's term of office, affirms the federal commitment. Every accredited
healthcare provider in the US publishes and widely distributes its policy statements detailing the consumers' rights and responsibilities.


34. United States Consumer Bill of Rights and Responsibilities, 1997

35. British Patients' Charter Rights


Notes: In Australia, the Medicare Public Patients' Hospital Charter, 1993-94 was developed as a model draft by the Commonwealth Government and the State and Territory governments during 1993-94, as statements of what consumers should expect from public hospital services. The Medicare Agreements required State and Territory governments to develop, publish and widely distribute the charters in English and community languages. The New South Wales government produced a Commitment to Service (1994) and in Victoria Putting Patients First (1995) was published covering service standards that patients can expect in all public health care services, not just hospitals. The Queensland government established by legislation, a Health Rights Commissioner and a Code of Health Rights and Responsibilities. The ACT Health Complaints Act 1993 and the Tasmanian Health Complaints Act 1995 provided for the establishment of independent health complaints bodies.

37. Patients' Charter of Hong Kong's Hospital Authority

38. Federation of Malaysian Consumers Associations (FOMCA), 1996

Notes: The Malaysian Medical Association (MMA), Malaysian Dental Association (MDA), Malaysian Pharmaceutical Society were co-signatories to this charter.


