CHAPTER 2

REVIEW OF LITERATURE

2.1 HEALTHCARE MARKETING AND CONSUMER SATISFACTION

Healthcare marketing is a recent development in the fields of healthcare. In these last three decades that healthcare marketing has been in vogue there has been a significant development in the field of healthcare marketing. This has been ascribed primarily to the changing consumer demand and the growing competition.

In an increasingly competitive and resource regulated market, the hospital managers must develop alternatives and heavily borrow some proven marketing techniques from business and incorporate it into health services. This is necessary for the survival of the hospitals and healthcare organizations.

Marketing concepts, tools, techniques and strategies that were once exclusive to the product and other industries are now being extensively and successfully applied to healthcare organizations, the concept of marketing is being firmly entrenched. Irrespective of the techniques and strategy applied, patient satisfaction remains the final goal of marketing.

Satisfaction is defined\(^1\) as 'being supplied fully with what is needed, desired or expected'. Implicit to this definition is the concept of need and desire and its fulfilment. These are the basic tenets of marketing. Satisfaction, in other words, is the fulfilment of needs and desires. This, as mentioned earlier, is also the basic definition of marketing.\(^2\)
Satisfaction can be thus considered as the consistency between the desires or expectations and their fulfilment. Since fulfilment of the desires or expectations is a function of the service provided by the health care organization, patient satisfaction can also be broadly defined as a personal assessment of health care services and providers. Pascoe\(^3\) defines patient satisfaction as a health care recipient's assessment of salient aspects of his or her service experience. Even though satisfaction is a process measure, patient satisfaction is important in outcome evaluations because the literature has shown a strong correlation between patient satisfaction and quality of care, and because higher satisfaction levels have been shown to correspond with actual behaviour changes.\(^4\) Satisfied patients have been shown to have a more stable relationship with a physician or health care provider, keep appointments, comply with advice and treatment, and refer other clients for treatment.\(^5\)

All customers perceive service in their own unique, idiosyncratic, emotional, irrational and human terms.\(^6\) This makes satisfaction highly subjective. This is more so in the case of healthcare. The needs and wants being ill defined, the perceived benefits of healthcare may not be near a person's expectation and hence the resultant dissatisfaction. Furthermore the inherent inability to fully comprehend the complexities of medical science and that of the human body furthers the gap between expectation and the perceived benefit and increases dissatisfaction. A patient may be correctly diagnosed and treated but the side effect of the medication, not within the control of the physician, may leave the patient dissatisfied with the service as a whole. A successful surgery may cause scar that may leave the patient dissatisfied with the surgery. Furthermore, as mentioned earlier, many times there is an apparent conflict between patient wants and the medical needs. Meeting medical needs, which is the primary purpose of the healthcare, rather than the patient wants, may leave the patient dissatisfied with the service provided.

In many situations patient's want may conflict with those of other markets in healthcare. Patient's want for time off work may conflict with the interests of the employer, his want for a expensive investigation may conflict with that of the health insurers who want cost-effectiveness, or his want for regular night time sedative may
conflict with that of the regulatory bodies who limit the sale of these drugs. All this may lead to dissatisfaction with the healthcare services with no fault of the services per se. The conflict between the wants of one group and those of the other requires being resolved.

In spite of the limited control over patient satisfaction in healthcare, patient satisfaction has always been and will, to a greater extent, continue to be a fundamental requirement for the clinical and financial success of any healthcare organization.

Patient satisfaction leads to improved patient compliance, increased patient referrals, greater patient loyalty, less patient complaints, increased third party, employer and other payers mandate and increased profitability. One unique feature in healthcare is the fact that the measure of patient satisfaction, among others, is now being used as one of the attributes that is considered by regulating agencies and managed care organizations before providing accreditation to healthcare organizations. Thus patient satisfaction is not only necessary for the financial success but for the very functioning of the organization.

In the last three decades lot of research has taken place in the field of marketing of healthcare services and consumer satisfaction in healthcare. The scope of the research varies from the need of conducting a patient satisfaction survey to the effect of the survey on the organization. Some of these studies are reviewed in the following chapters.
2.2 THE DEFINITION OF CONSUMER SATISFACTION

The interest in consumer satisfaction was instilled in 1965 with Cardozo's classic article. Since then the last three and a half decades has seen a phenomenon growth in the conceptualisation, evaluation, discussion and communication of consumer satisfaction. In spite of this, researchers have yet to develop a consensual definition of consumer satisfaction. Although, consumer satisfaction literature is full of different conceptual and operational definitions of consumer satisfaction there seems to be no consensus between them. A basic definitional inconsistency is evident by the debate of whether satisfaction is a process or an outcome. Most definitions have favoured the notion of consumer satisfaction as a response to an evaluation process.

Researchers have also used different terms to mean satisfaction as determined by the final user: consumer satisfaction (e.g., Cronin and Taylor; Oliver; Spreng et al), customer satisfaction (e.g., Churchill and Surprenant; Halstead et al; Smith et al), or simply, satisfaction (e.g., Oliver and Swan; Mittal et al). These terms are used somewhat interchangeably and in any case focus on the end user. In this research the term 'consumer satisfaction' is generally used.

The lack of a consensus definition for satisfaction creates three serious problems for any consumer satisfaction research: selecting an appropriate definition for a given study; operationalising the definition; and interpreting and comparing empirical results. These three problems affect the basic structure and outcomes of marketing research and theory testing. It is therefore essential to create a unified definition of consumer satisfaction.

Furthermore, it is imperative to define and measure satisfaction according to consumers' views of the relevant satisfaction situation. For these and other reasons, Yi concludes that, 'for the field of consumer satisfaction to develop further, a clear definition of consumer satisfaction is needed'.
Consumer is defined as the ultimate user of the product. Although the focus is on the end user of the product, it is recognised that, in some situations, the end user is also the purchaser.

There are many definitions of consumer satisfaction.

Oliver defines it as a judgment that a product or service feature, or the product or service itself, provided (or is providing) a pleasurable level of consumption-related fulfilment. Halstead et al define it as customer’s comparison of product performance to some pre-purchase standard. This view is also endorsed by Fornell, according to whom, satisfaction is an overall post purchase evaluation of the perceived product performance compared with pre-purchase expectations. A similar view is also echoed by Tse and Wilton, who define consumer satisfaction as the consumer’s post-consumption response to the evaluation of the perceived discrepancy between prior expectations and the actual performance of the product as perceived after its consumption. Westbrook and Reilly consider consumer satisfaction as an emotional triggered by a cognitive evaluative process in which the perceptions of (or beliefs about) an object, action, or condition are compared to one’s values (or needs, wants, desires).

Consumer satisfaction has been typically considered as either an emotional or cognitive response. Westbrook and Reilly refer to satisfaction as ‘an emotional response’, while Howard and Sheth refer to it as ‘a buyer’s cognitive state’. Furthermore, there are several definitions indicating that the response may be comprised of both cognitive and affective dimensions. More recent satisfaction definitions consider consumer satisfaction as both cognitive as well as emotional.

Satisfaction can be determined at various points in time. It is generally accepted that consumer satisfaction is a post purchase phenomenon and that the product must have been consumed or the service experienced before satisfaction is determined. It is possible for satisfaction to occur prior to the choice, purchase, or consumption.
For the purpose of this study the modified version of the definition of Tse and Wilton is used. Consumer satisfaction is defined as ‘the consumer’s emotional and cognitive response to the evaluation of the perceived discrepancy between prior expectation (for some norm of performance) and the actual performance of the product as perceived after its consumption’.

2.3 CONSUMER SATISFACTION AND CONSUMER LOYALTY

As already mentioned, the for-profit healthcare market of today, (especially in the west, and very soon in the developing countries), is plagued with competition. Competition and oversupply in the market creates consumer choice, where they are free to choose between the different offerings in the market. Consumers look for various benefits including quality of service and value for money before exercising their choice.

Organizations, including healthcare, attempt to attract these demanding consumers using various techniques including increased benefit, decrease price, market communications etc. Unfortunately all of these attempts are prone to imitation, sooner or later. This imitation leads to more competition. In this situation where attracting new consumer is difficult the important of retaining the old consumer is of prime importance. This is a function of consumer satisfaction followed by consumer loyalty.

As mentioned earlier, there is a fundamental difference between satisfaction and loyalty though in many areas it is used interchangeably. Satisfaction is an attitude that results from the perception of the services offered by the organization to the consumer. Loyalty on the other hand is a behaviour that results from satisfaction. Although satisfaction is a necessary antecedent to loyalty, it does not guarantee loyalty. Loyalty is a step ahead of satisfaction.
Many organizations, especially those in the field of healthcare, are now turning their attention to consumer loyalty. Consumer satisfaction and retention has become the prime target of marketing.

According to Day et al, there are only two sources of competitive advantage for a firm: superior skills and superior resources. Some companies have both. Superior skills include better resources in human talent, technology, abilities, or competencies. Superior resources include greater capital, better productive capacity, better location and access and the like. With these resources an organization can compete in two ways either through low cost or through increased differentiation from other services, mainly in terms of quality.

The low-cost competitor can produce and deliver the product or service at the lowest price, with the advantages of margin and pricing flexibility this confers. Those unable or unwilling to achieve the low-cost position must make the product or service bigger, of better quality and superior, or in a wider range than other. In short, to compete successfully at best and survive at least, they must differentiate the service or product offerings in ways that the consumer values and is prepared to pay for.

Porter et al suggest that these two strategies are mutually exclusive and that it is not possible to have low costs and differentiation. An organization needs to continuously assess the outcomes of the strategies so as to modify the strategy to remain in apposition of competitive advantage.

According to Anderson et al, the outcomes that are normally evident are financial productivity, measured by a return on investment or any other financial variable, increased market share, or at least maintaining it, consumer satisfaction and consumer loyalty. Satisfied consumers tend to remain loyal to a company that satisfies them and despite the available choice, they will refrain from patronizing competitors.
Most managers pay more attention to the outcomes of market share and financial productivity, neglecting the other outcomes of patient satisfaction and loyalty.41

Financial productivity and related outcomes are easy to assess and analyse. They can be expressed in numbers that can be easily calculated and compared. The problem is that they are historical, they reflect on what has happened in the past, but are an inadequate indication of the future.

Consumer satisfaction and loyalty are concepts that are more vague and difficult to measure. They are, but, forward looking statistics that can foretell the future of the organization. For most products and services the consumers are not so fickle so as to be satisfied today and dissatisfied with the same good offering tomorrow. The problem with most measures of consumer satisfaction and loyalty is that they are soft and impression-based.42 They are, however, the future.

Any organization will invest in anything that will give it a competitive advantage, either superior skills or superior resources so that it can compete better in the market. With this in mind organizations are now investing in patient loyalty. Traditional accounting systems have viewed consumers as sources of revenue. More and more, however, firms are beginning to use their accounting systems to view consumers as assets, basing their decisions on consumers much as they would base their decisions on investments.

Increase in consumer loyalty increases the value of the consumer to the organization. This had been termed as ‘consumer life time value (CLTV)’.43 Organizations attempt to increase the CLTV by various means, including:

1. Increasing lifetime, by raising either the retention rate or the consumer life (the number of years a consumer can remain a consumer);
2. Increasing sales to, or as a result of, a consumer. This includes raising either the firm's share of the consumer's purchases or increasing the consumer's referral rate;
3. Cutting the costs of serving a consumer.

As evident, all three means noted above require a satisfied patient.
A vast range of industries focuses on consumer retention and loyalty nowadays. Healthcare industries although have noted the importance of patient loyalty for long have not dealt with it in a more scientific way.

According to Hirschman\textsuperscript{44} consumer loyalty is a function of both the consumer's unwillingness to exit and his ability to exert his voice. Consumers remain loyal not only when they are satisfied with the product or service but also when they feel that their opinion, positive or negative, is being attended to. This makes them feel a part of the system. This is another advantage of a continuous patient satisfaction survey.

Many organizations attempt to increase consumer loyalty by monetary gain and financial inducements like concessions on follow up in healthcare, frequent flyer miles in airlines etc. This is referred to as the "economics of loyalty". Others focus on improving the quality of service and offerings and encourage consumers to voice their opinion and follow it up. This is termed as the "politics of loyalty". In the long run the economics of loyalty may not be beneficial because consumers may tolerate poor service quality for financial gain. True loyalty is a result of improving the politics of loyalty.

Blattberg et al\textsuperscript{45} state that marketing should be managed by the consumer loyalty criterion. Thus, any marketing decision should be evaluated on whether or not they increase consumer loyalty.

In order to manage consumer loyalty an organization needs first to be able to identify and measure satisfaction and loyalty in the various aspects and elements that make it up. Second, is the issue of managing and motivating consumer contact level staff. Whereas traditional systems tend to reward transactions and volume, there will be a growing need to focus equally on issues of retention. Heskett et al\textsuperscript{46} have proposed a service-profit chain according to which profit and growth are stimulated primarily by consumer loyalty, which is a direct result of consumer satisfaction, which is largely influenced by the quality and value of services offered to consumers.
2.4 NEED FOR CONSUMER SATISFACTION ASSESSMENT

Of the various marketing and market research activities being undertaken by healthcare organizations in the present scenario, one of the most basic and perhaps the most important is consumer (patient) satisfaction assessment. A through knowledge of the needs and wants of the organization’s patients and the extent to which the organization is able to satisfy them is essential for any marketing activity. This is one research that precedes most of the marketing activity of the organization.

A private hospital can ill afford to ignore patient’s wants and expectations and fulfilling them because dissatisfied patients and consequent falling patient strength can lead to financial non-viability, exodus of doctors, diminished benefactor support and other undesirable consequences.

A hospital needs to engage in satisfaction survey for the basic reason of knowing what the specific needs of the consumers are and how well it fulfills it. It also needs to know the degree of satisfaction consumers have with the services the hospital provides and the relative strength and weakness of the hospital. Not only this, the patient satisfaction assessment is necessary for troubleshooting, complaint resolution and collection of baseline data. It is also necessary for getting in corporate clients and large employers to patronise the hospitals, managed care organizations for including the hospital in their referrals and also for accreditation of the facility. Patient satisfaction assessment is necessary to determine the direction in which to focus on in order to get continued consumer patronage, attract new clientele and judiciously use the resources available.

The need and therefore the use of patient satisfaction assessment are thus many. The following text outlines some of these.
UNDERSTAND THE PATIENT NEEDS, WANTS AND DEMANDS
The basic function of the patient satisfaction assessment is to understand the need wants and the demands of the patient. Unless the needs and wants and demands of the patient are known and understood, attempts to fulfil them, if any, will be totally non-directional.

IMPROVE PATIENT SATISFACTION
The fundamental premise of the patient satisfaction assessment is to increase the patient satisfaction. Patient dissatisfaction can have a number of undesirable consequences for the hospital. These have already been mentioned earlier.

INCREASE PATIENT LOYALTY
Patient loyalty is a function of patient satisfaction. Satisfaction leads to loyalty. Satisfaction is an attitude and loyalty is a behaviour that follows a positive attitude towards the hospital or healthcare facility. Loyalty adds lot of value to the organisations, as retaining a loyal customer is both easy and less resource consuming than attracting a new client.

MEET THE SERVICE QUALITY DEMands
Today’s consumer has more expectation of the service quality than ever before. As the age of consumerism catches on in the healthcare sector, understanding the patient is of vital importance. Not only this, in a changing environment as is with the field of healthcare today, the needs wants demands and expectations of the patients constantly keep on changing. As present expectations are met and even exceeded new expectation emerge. A periodic patient satisfaction assessment is necessary for the health care organization to keep abreast with these changes.

IMPROVE PATIENT SEGMENTATION
Healthcare services of today, like most of the consumer services, have to be patient specific. It is not possible to satisfy all patients all the time especially in view of the limited resources an organisation may have in hand. Thus it is necessary to segment the patient population in a way that can be best served by the healthcare facility in
line with its unique strengths and weaknesses. A patient satisfaction assessment can help the gauge the unique strength and weakness of the health care facility and on the basis on which it can improve patient segmentation in order to determine the group of patients on which to focus maximum attention.

**IMPROVE DIFFERENTIATION**

With emerging competition hospitals today need to differentiate themselves from other. Many of them differentiate by way of service provided. Knowledge of the patients and their needs and wants is necessary before a hospital can differentiate its services from others. This is where the role of patient satisfaction assessment comes in. Even where different healthcare facilities provide the same technical services, patients being unable to gauge the technical aspect of the service, determine their satisfaction on the non-technical aspects of care like empathy responsiveness and communication with the staff. A hospital can differentiate itself from the others by improving these non-technical aspects. For this a satisfaction assessment is essential.

**IMPROVE MARKET COMMUNICATION**

A patient satisfaction assessment gives the healthcare facility a base on which to build market communications that can project a positive image of the hospital on the community and thus on its prospective consumers. This is very important as hospitals and healthcare organisations are increasingly coming under close media scrutiny in view of the increasing number of negative media images of these organisations.

**INCREASE PATIENT REFERRALS**

When service meets or exceeds expectation the patient feels satisfied. A satisfied patient conveys his feeling to other. This results in greater patient to patient referrals. Doctors who refer patients to the facility also constantly monitor the patient satisfaction at the facility that they are referring the patient to. This is because a patient satisfied with the facility where he was referred to, is also satisfied with the referring doctor. The converse is also true.
DECREASE PATIENT COMPLAINTS & LITIGATION

It is obvious that satisfied patients rarely, if ever, complain or initiate malpractice cases. With litigation so common in the field of healthcare, especially with the consumer courts now increasing their purview to include healthcare facility, this aspect has been increasingly important. An assessment of the patient satisfaction is essential to increase patient satisfaction with the healthcare facility and thereby decreases the amount of complaints and litigation.

PAYERS REQUIREMENT

In today’s healthcare scenario, in many cases, the patient is not necessarily the payer of the health services he utilises. Payers may be employers, large corporations or insurance companies. These payers always demand a value for money. Patient’s satisfaction is one of the techniques used by them to gauge this. These payers direct patient to facilities that provide greater patient satisfaction.

ACCREDITING AGENCY REQUIREMENT

Hospitals and healthcare facilities, especially in the developed world and now also in India, are increasingly seeking accreditation by various regulatory and accrediting agency. This may or may not be a statutory requirement. ISO 9000 series and JCAHO (Joint Commission on Accreditation of Healthcare Organisation) accreditation are increasingly being heard of in hospitals and healthcare facilities even in India. One of the basic requirements of these accrediting agencies is an active and ongoing patient satisfaction assessment.

INTERNAL MARKETING BENEFITS

Internal marketing is the work done by the hospital to satisfy its employees and to train and motivate the employees to serve the patients well. A satisfied employee is more willing to change his / her attitude and behaviour so as to become more patient oriented. For this reason, the ambit of consumers and customers has been increased to include the employees of the hospital. Satisfaction assessment can help in directing the effort towards increasing the satisfaction of the employees and thereby indirectly increasing the satisfaction of the patients.
INCREASE PROFIT

The basic objective of most of the private healthcare centres and hospitals is an increase in profit. This may not necessarily be the reason for existence for these private hospitals but it is definitely necessary for survival. Patient satisfaction and consequent patient loyalty is necessary for financial viability and profit generation and hence the need for patient satisfaction assessment.

2.5 CONSUMER SATISFACTION & HEALTHCARE QUALITY

For quite some time, people within the healthcare profession have been concerned about assessing the quality of healthcare so that providers could improve it. Florence Nightingale in the field hospitals of the Crimean War and Ernest Codman in Boston’s surgical wards during the early 20th century were part of this tradition. Although experts from other fields, such as management and statistics, contributed techniques to evaluate the quality of healthcare, until lately assessments of quality remained largely within the purview of the healthcare profession.

Noting that patient in some mid-19th century London hospitals fared better than in others, Florence Nightingale in 1863 first called for systematic inquiry into the nature of care processes which might be related to this outcome variability. Boston surgeon Ernest Codman, similarly noted such variation and called for systematic inquiry regarding the care processes.

Although the marketing of healthcare service followed marketing of other services by more than five decades, the origins of systematic institutional enquiry into the quality in manufacturing sector coincided almost precisely with the early efforts of the American College of Surgeons for assessing and assuring quality in healthcare.

In 1917, G. S. Radford authored a journal article calling for quality as a distinct and independent management responsibility. The American College of Surgeons (ACS)
in 1913 had established quality of hospital care as a founding principle and subsequently formalized this principle in the form of its 1917 Hospital Standardization Program.\textsuperscript{50} The quality evaluation program developed in 1917 was retrospective case review and peer discussion. This method had peer clinicians reviewing the records of patients, most often those experiencing some adverse occurrence (death, complication, etc.), considering whether alternative approaches might have led to a better outcome.

The Hospital Standardization Program was notably successful in improving healthcare quality of the era.\textsuperscript{51} This success culminated in 1951, when the American Medical Association, American College of Physicians, the American Hospital Association, and the Canadian Hospital Association joined American College of Surgeons to form the Joint Commission on Accreditation of Hospitals (JCAHO) in the USA.\textsuperscript{52} The JCAHO was (and still is) responsible for monitoring healthcare organizations for quality. Such standardization programmes, however, did not evolve in other parts of the world.

Quality standards evolved slowly through the 1950s and early 1960s. In the mid 1960s medical associations and standardization programmes progressively encouraged methods that moved beyond case review as the sole method of quality assessment and into analysis derived from data encompassing large numbers of patients.\textsuperscript{53} The criteria of comparing the observation in quality standard in a healthcare setting against pre-set standard or threshold was developed.

Unlike the rest of the industries, however, quality programmes in healthcare did not pay attention to consumer satisfaction. It was the doctors' mentality that healthcare is a special thing and that the only people trained well enough to really understand the difference between what happened and what was supposed to happen are the doctors.\textsuperscript{54} The consumers in healthcare had no say in deciding upon the quality of care.
DONABEDIAN’S SPO MODEL OF SERVICE QUALITY MEASUREMENT

In 1966, Avendis Donabedian proposed the structure/process/outcome (SPO) model as a measure of healthcare quality. Donabedian defined structural measures of quality as the professional and organizational resources associated with the provision of care, such as staff credentials and facility operating capacities. Process measures of quality referred to the things done to and for the patient by the healthcare organization in the course of treatment. Outcome measures were the desired states resulting from care processes, which included technical outcomes like reduction in morbidity and mortality, and interpersonal outcomes like patient satisfaction and improvement in the quality of life. Donabedian was first to describe the distinction between the technical outcomes and functional quality of care. Within Donabedian’s framework, these two types of outcomes are interdependent, so that one cannot be considered in isolation from the other in evaluating the quality of care.

Thus Donabedian was the first to introduce the process measures of quality or the assessment of quality for the patient’s point of view. It was only after this that research and studies in healthcare quality began to focus on both the medical outcome of the care as well as the consumers’ satisfaction with the care provided.

Quality is an essential element of all service. It is, however, difficult to define quality in any other terms except in terms of user satisfaction. What constitutes quality, especially in the service industry, relies solely on the perception of the consumer. Further, the nature of service, especially healthcare, makes it difficult to develop valid and reliable measures of service quality except in relation with patient satisfaction. This implies that the consumer or patient’s satisfaction with a service is a measure of its quality.

Service quality is predominantly defined as the measure of how well the perceived level of service delivered matches the user expectation. Zeithaml et al after conducting a search for the definition of service quality concluded, “Service quality, as perceived by customers, can be defined as the extent of discrepancy between the
Understanding the dimensions of service quality is a way of assessing what the customers desire for in a service and what are their expectations for the service. It is also a measure of the perception of the customers in respect to the services provided. The difference between the two is a measure of patient satisfaction. Measuring service quality is a measure of patient satisfaction. Asking the consumer “is the service provided satisfactory” is the same as asking, “are you satisfied with our service”.

There are various scales that have been developed and validated in a variety of setting that measure the service quality. They have also been used as a measure of patient satisfaction and appraise the marketing policies and practices of the institution. Some of these scales are reviewed below.

**THE SERVQUAL SCALE FOR SERVICE QUALITY MEASUREMENT**

The most widely known and discussed scale for measuring service quality is SERVQUAL, a scale designed to measure five dimensions of service quality: tangibles, reliability, responsiveness, assurance, and empathy. It was developed by Zeithaml, Berry and Parasuraman and first proposed in 1985 and has been modified since. It was initially meant for service sectors other than healthcare but has been now modified and adapted to the healthcare service.

The SERVQUAL instrument for measuring service quality was derived by evaluating 10 evaluative dimensions obtained through exploratory research. These evaluative dimensions of service quality that form the foundation of the SERVQUAL survey instrument, as adapted to healthcare, are as follows:
1. **TANGIBLES**
   This implies the appearance of the physical facilities its cleanliness, neatness, lighting, noise levels, smell, presence of conveniently located basic amenities like drinking water, rest rooms, elevators. Other dimension of quality includes appearance of the equipments whether up-to data, communication facilities, networking on computers. These tangibles are taken for granted in more developed countries and are severely lacking or absent in developing and underdeveloped countries and areas. However, service quality and patient satisfaction being a function of the expected, the expectation of the customers in lesser developed countries with regard to these tangibles differ widely from that in developed ones. Since there is no measure for the quality of these tangibles, except surveying the patient for their expectation and satisfaction of the same, service quality or satisfaction surveys are necessary to clarify the quality of the tangibles.

2. **RELIABILITY**
   Reliability involves consistence of performance and dependability. It implies the ability to perform the promised service dependably and accurately. Return of the test report on the promised date and the accuracy of the report are both examples of the measure of reliability of a healthcare organization. Reliability is becoming more important as choices for customers increase and customers go in for a confirmation and reconfirmation of their tests reports and even for second opinion for the diagnosis of their medical condition. Reliability has both qualitative and quantitative aspects. The qualitative aspect of reliability is based on the patient’s perception while the quantitative aspect is based on the comparison of the outcome with other organizations.

3. **RESPONSIVENESS**
   Responsiveness concerns the willingness or readiness of the service personnel to provide service. Responsiveness is the timely and accurate reaction to a customer’s need and want and the willingness to satisfy them. Responsiveness is the dimension that involves all members of the organization and is both an
attitude and a behavior. Communication and understanding are essential elements of responsiveness.

4. COMPETENCE

Competence is the possession of the required skills and knowledge to perform a particular service. It implies both qualification and capabilities required for a particular service. The more complex the service, the more important is the competence of the provider. Here again, the quality dimension of competence is in the patient's frame of reference. A surgeon may be competent for a particular surgery by virtue of his medical qualification, training, experience and even certification, but for patient satisfaction and it is the patient's perception as to whether he is competent or not is what matters. Hence competence is based on the patient's perception.

5. COURTESY

Courtesy extended to the customer includes politeness, respect, consideration and friendliness of the person with which the customer is in contact in the organization. Courtesy as a service quality dimension of a healthcare organization includes the sum total of the encounters with all personnel including doctors, nurses, receptionist, pharmacists etc. The patient see the hospital through the employees with whom they come in contact and the relation of these contact personnel with the patients is an important dimension of service quality and marketing. In the case of healthcare organizations especially, the service not only requires to be 'hi-tech' but also 'hi-touch'. This is because, in the healthcare organizations, most of the time, the patients cannot judge the technical quality even after they have received the services.

6. CREDIBILITY

Credibility involves trustworthiness, believability and honesty. It involves the customers' best interest at heart. Trustworthiness and honesty are important qualities patient look for in a healthcare provider. These qualities are generally propagated by word of mouth. Since patients do not understand the technical
aspect of the service they have to rely substantially on the credibility of the provider to give them proper and correct advise and service. Many for-profit healthcare organizations have been accused of subjecting patients to unnecessary investigation, uncalled for therapeutic procedures, unessential medications and even unwarranted surgeries. In fact credibility of for-profit healthcare organizations in general, especially in developing countries, has been severely tarnished. In such a situation a good credibility in the market is a strong quality.

7. SECURITY
Security in context of healthcare organizations service quality includes not only freedom from danger but also freedom from risk or doubt. It has both physical and mental connotations. In the physical sense it means freedom from physical harm and the various aspects the patient looks for is lighting of corridors and staircases, security personnel at strategic points etc. In the mental sense it means a reducing the risk associated with the treatment and clarifying any queries or doubts regarding the medical problem and its treatment, including complications and side effects. Because of the poor understanding of the technical aspects of the treatment, especially in more complex cases, patient’s concern is largely related to whether the provider will explain the potential risks and complication of treatment in relation to the complications of the medical condition itself. Understanding a patient’s security concerns and addressing them is an important dimension of service quality.

8. ACCESS
Access includes approachability and ease of contact. This includes location, timings, ease of scheduling appointment and procedures, response to telephonic and now email enquiries, waiting time, access to emergency medical care, follow up and contacting the health provider when required. All these are important dimensions in the perception of service quality. In today’s scenario time has significant value and the process required for arranging for and
obtaining healthcare should be minimized in order to improve the service quality.

9. COMMUNICATION
It is ironical that even though the means of communication have increased vastly both in quantity and quality, the actual process of communication has reduced. Talking to the patient and satisfying him has becoming more and important. It is not only an important measure of the service quality but influences other measures. A patient is usually unable to understand his own medical problem, let alone the intricacies of medical science. In this situation communication with the patient is rated highly as a service quality measure.

10. UNDERSTANDING
This involves an effort on the part of the provider to know the customer as an individual and his needs. Provider generally tend to treat patient as medical cases rather individuals with needs, desires and expectations which are unique to a particular person. This individualization of service is important measure of the service quality.

Based on the above 10 dimension the SERVQUAL instrument has been modified to include five dimensions that capture the essence of the original 10 dimensions. These and their definition is as follows:

1. TANGIBLES: the appearance of the physical facilities, equipment, personnel and communication material.
2. RELIABILITY: The ability to perform the promised service dependably and accurately.
3. RESPONSIVENESS: A willingness to help customers and provide prompt service.
4. ASSURANCE: Knowledge and courtesy of the employees and their ability to convey trust and confidence.
5. EMPATHY: Caring, individualized attention that the organization provides its customers.
SERVQUAL has been empirically tested in a number of studies involving a variety of service settings including healthcare and has been adapted in a healthcare environment. Research using SERVQUAL in healthcare settings has focused on patient satisfaction and perceptions of quality.\textsuperscript{66,67,68}

The intention for SERVQUAL to be used as a generic measure in any service setting has been challenged by a number of studies.\textsuperscript{69,70} Despite this, the scale or its modification has been extensively used in healthcare with good success. The scale has been used in various healthcare facilities including nursing homes\textsuperscript{71} and hospitals\textsuperscript{72} and also for specific healthcare services like nursing care\textsuperscript{73} and blood bank.\textsuperscript{74}

**THE MARTIN MODEL FOR SERVICE QUALITY MEASUREMENT**

In 1989, Martin proposed a two-dimensional model for service quality.\textsuperscript{75} The two dimensions are procedural dimension and personal dimension. The procedural dimension includes all systems, processes and mechanisms that an organization uses to accomplish its work and meet the customer's need. The personal dimension represents the human side of the service. In the Martin model the procedural dimension of service, adapted for healthcare, has seven areas that need to be addressed by the organization. These are:

A. PROCEDURAL DIMENSION OF SERVICE

1. **TIMING**

   Timing relates to access in the SERVQUAL model. Time taken to answer to telephone call, to schedule appointment, waiting time at the reception, the waiting time for various other procedures and at the pharmacy is an important service dimension.

2. **FLOW LOGIC**

   This relates to the processes and systems through which the services are delivered and obtained. Registration counter, reception, admission counter, cashier,
pharmacy etc are processes through which a patient has to go to obtain the service. These systems should be simple, patient friendly, quick and efficient. It is important to design such a system and to eliminate, combine or rearrange the steps so as to minimize the queuing period, duplication of effort and improve the efficiency of the system and to form a smoother sequence.

3. ACCOMMODATION
This refers to personalization of care and the flexibility of the system to adapt to the individual needs of the customer. This area conforms to the ‘understanding’ dimension on the SERVQUAL scale.

4. ANTICIPATION
This dimension reflects the empathy and understanding of the organization to the customer’s need. Consumer’s value organizations that anticipate and provide for the patients needs without being explicitly told to do so.

5. COMMUNICATION
This refers to communication not only between the consumer and the health care team but also within the healthcare team itself. Patient exact clear and detailed explanations of their problem, in a language they can understand, clear instructions and recommendations.

6. PATIENT FEEDBACK
Patient value organization that actively solicit their opinions and listen to their concerns and then take active steps to respond to it. Giving patients opportunity to air their grievances not only improves the perception of service quality but provides an important feedback to the organization to improve its services.

7. ORGANIZATION AND SUPERVISION
Patients expect to receive the same kind of service from all members of the healthcare team. This requires organization and supervision of the personnel and patient point of interactions.
The personal dimension of service quality has six areas as follows:

B. THE PERSONAL DIMENSIONS OF SERVICE

1. APPEARANCE
   This includes the appearance of the healthcare facility both from outside and inside and also the appearance of the personnel and the healthcare team dealing with the patient. This pertains to tangibles on the SERVQUAL scale.

2. ATTITUDE, BODY LANGUAGE
   The attitude that makes the patient feel welcome to the healthcare facility is very important. The perception begins from the first telephone call and carries right through his obtaining the service. Not only the words but also the tone of voice and body language help form the patient's perception.

3. ATTENTIVENESS
   Patient seeks attention and wants the healthcare team to be interested in them as an individual and in their problem. This is included in 'empathy' on the SERVQUAL scale.

4. TACT
   In situation where the patient seeks medical helps for a condition that is a consequence to his intemperate lifestyle, it is important to deal with the situation with tact. Tact involves a right choice of words communicate the problem to the patient without offending him or hurting his feeling. This is another aspect of 'empathy' on the SERVQUAL scale.

5. GUIDANCE
   This is the help required by the patient to go through the various processes and systems that make up the complex modern health care facility. Help in required not only locating the various parts of the facilities but also with the various
forms and other paperwork. This is part of the ‘responsiveness’ dimension on the SERVQUAL scale.

6. GRACIOUS PROBLEM SOLVING

The modern healthcare facility is complex and even though patients take minute problems in their stride they expect that the problems will be listened to and addressed. This is also part of the ‘responsiveness’ dimension on the SERVQUAL scale.

Comparing the SERVQUAL dimensions and the Martin’s model it is apparent that most of the dimensions in the two are common although may be worded differently.

Comparing SERVQUAL dimensions to his own qualitative research, Dabholkar suggested that SERVQUAL dimensions need modification and require a hierarchical factor structure to better capture overall evaluations of service quality. Dabholkar, Thorpe and Rentz in 1996 proposed five dimensions central to service quality. According to them the five dimensions are:

1. Physical aspects,
2. Reliability,
3. Personal interaction,
4. Problem solving, and
5. Policy.

The dimensions proposed by them appear no different from those suggested in earlier studies.

PRIMARY CARE ASSESSMENT SURVEY OF CONSUM. SATISFACTION

Another scale that has been recently used to assess the quality of service and care provided and the patient satisfaction with the service provided is the Primary Care Assessment Survey (PCAS). The PCAS differs from other scales because it has been primarily been constructed for use in the healthcare services.
The PCAS is a validated patient-completed questionnaire that measures 8 essential dimensions of primary care, defined by the Institute of Medicine Committee on the Future of Primary Care. Although designed for assessment of service in primary care the scale can be modified in context for institutional care and the dimensions of the scale are equally pertinent to any healthcare organization.

The PCAS scale covers 2 broad aspects of the patient’s primary care experience: the quality of the primary care relationship (4 scales: quality of communication, interpersonal treatment, physician’s knowledge of the patient, patient trust) and organizational features of care (4 scales: financial access, organizational access, visit-based continuity, integration of care). The various dimensions of PCAS as modified for healthcare institutions are as follows:

A. PERSONAL FEATURES OF CARE

1. COMMUNICATION
   This includes thoroughness of primary physician’s questions about symptoms and attention to what the patient says and advice and help in making decisions about care. This also includes the physician’s and other personnel’s clarity of explanations and instructions. Communication is a common factor in all scales.

2. INTERPERSONAL TREATMENT
   This concerns the primary physician’s and the healthcare team’s patience, friendliness, caring, respect, and time spent with patient. This relates to ‘empathy’ on the SERVQUAL scale.

3. KNOWLEDGE OF THE PATIENT
   Primary physician’s knowledge of patient’s medical history; responsibilities at work, home, or school; principal health concerns values and beliefs. In brief, it includes understanding of the patient as a person.
4. TRUST
This is based on the assessment of primary physician’s and healthcare organization’s integrity, competence, and role as the patient’s agent. This is equivalent to ‘credibility’.

B. STRUCTURAL/ORGANIZATIONAL FEATURE OF CARE

1. FINANCIAL ACCESS TO CARE
This includes the cost of the service obtained, the amount of money the patient pays for consultation, procedures, medication and other prescribed treatments. Also includes the relation between the costs and the service provided.

2. ORGANIZATIONAL ACCESS TO CARE
Ability to get through to the physician’s office by telephone, to get a medical appointment when sick, and to obtain information by telephone, punctuality of appointments, convenience of office location, and convenience of office hours. This is equivalent to ‘access’ on the other scales.

3. CONTINUITY OF CARE
This reflects the need to see the same physician for follow-up and for future appointments. This is because the patient-physician interaction builds a relationship that gives security to the patient.

4. INTEGRATION OF CARE
This reflects the assessment of the physician’s role in coordinating and synthesizing care received from other physicians and specialists and/or while patient was hospitalised.

As evident, most of the dimensions on the PCAS scale are similar to the ones already described in the other scales. However the PCAS scale introduces a new dimension namely the financial cost of the service provided. This may not be important for patients who are covered under managed care, insurances and other third party payers.
but is one of the important dimensions for patients who pay for the service received. Not only the actual cost of the service but also the value-for-money concept is important in healthcare as it is in any industry and for any product.

Linder-Pelz et al have also included financial aspects as one of the dimension of service quality. They have identified 10 elements that, according to them, could be used to determine satisfaction. These include accessibility / convenience, availability of resources, continuity of care, efficacy / outcomes of care, financial consideration, compassion, information gathering, information providing, pleasantness of surroundings and quality / competence. These attributes are termed differently by different researchers in earlier scales.

In recent years, a number of forces have combined to promote consumer’s role in evaluating the quality healthcare providers. Efforts to advance consumer’s interests are occurring throughout society, and changes within healthcare are part of that societal trend. More specific to healthcare are changes that have brought more competition into healthcare. Consumers are now more knowledgeable and have options to exercise while selecting a healthcare facility. Purchasers of healthcare (individual consumers, employers, health insurers) need to know about any differences in quality so that they can weigh quality along with cost in making decisions.

In the present environment, at least three rationales lie behind the call for more public information on the quality of healthcare providers. The most immediate is that people seeking healthcare deserve information so that they can avoid poor providers and seek good providers. This rationale assumes that some healthcare providers may harm patients or may furnish care much inferior to that of other providers. The second rationale for more public information is that over a longer period of time, information on specific providers could form part of a larger effort to educate the public about the quality of healthcare. Indeed, informed consumers play a pivotal role in strategies to inject greater competition into the healthcare marketplace. A general educational effort could impart the knowledge and skills to enable people to appreciate
differences in the quality of care offered by healthcare providers. A third rationale for better public information on the quality of care is to stimulate the healthcare community, as a collective and as individuals, to improve their quality. From the choices of informed purchasers, healthcare providers can gain insight into what matters to people who seek healthcare. Some policymakers and healthcare professionals envisage that the increased knowledge from such feedback and the competition for patients will drive healthcare providers, both hospitals and physicians, to better their own practices.

The healthcare delivery system has made enormous advances, some to lengthen life and others to improve its quality. Perhaps the very successes of medicine have spawned the calls for more quality assessment and public information, for along with these achievements, public expectations of medicine and the public's stake in good quality care have risen. People now have much more to gain from medicine, and much more to lose from poor-quality care.

Several studies have found much room for improvement among different types of providers and disturbing variations in the use of healthcare procedures and hospital care. This makes it necessary to assess the quality of healthcare provided by a healthcare organization.

There has been recent debate in the literature regarding the relationship and overlap between the constructs of customer satisfaction and service quality. Studies now seek to merge service satisfaction with service quality by integrating them into one model. Bloemer and de Ruyter suggest that service quality should be treated as an antecedent of user satisfaction and that perception is a direct indicator of satisfaction, with expectations and disconfirmation having little influence on satisfaction. Identification of these perceptions will assist in framing research dimensions.

Not withstanding the difference between patient satisfaction and service quality, the assessment of both is similar. Instrument that reflect on service quality also give an insight into patient satisfaction. Organizations that are measuring the patient satisfaction are indirectly measuring their service quality. Both the criteria use
expectation and perception and the difference between the expectation and the final perception of the service as the basic constructs.

The intention of any quality assessment research is to generate quantifiable data from an appropriate sample of customers that allows it to objectify the perceptions concerning various dimensions of service offered by the healthcare organization. This also is the intention of the patient satisfaction survey.

This is the scope of this research also.

2.6 THE ELEMENTS OF MARKETING AND DIMENSIONS OF CONSUMER SATISFACTION

As mentioned earlier, the various studies that have studied the customer satisfaction and quality of healthcare have looked into various dimensions of consumer satisfaction and the healthcare quality.

These various dimensions have been named differently by different authors but in fact represent similar dimensions.

These dimension also represent the 7Ps of service marketing.

The following table compares the various dimensions of consumer satisfaction and healthcare quality among each other and also with the 7Ps of service marketing. The last column gives the dimensions that are being studies in this study.
### TABLE 1: COMPARISON OF THE VARIOUS DIMENSIONS OF CONSUMER SATISFACTION AND HEALTHCARE QUALITY

<table>
<thead>
<tr>
<th>DONABED*</th>
<th>SERVQUAL</th>
<th>MARTIN**</th>
<th>PCAS***</th>
<th>7Ps OF MKT.</th>
<th>PRESENT STUDY</th>
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<td>Product</td>
<td>Outcome</td>
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<td>Organ. access</td>
<td>Place</td>
<td>Access</td>
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<td>Integ. of care</td>
<td>Process</td>
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<td>Accommodat.</td>
<td>Interp. treatm.</td>
<td>People</td>
<td>Empathy</td>
</tr>
<tr>
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<td>Anticipation</td>
<td>Knowl. of pt.</td>
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<td>Empathy</td>
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<td>Communicat</td>
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<tr>
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<td>--</td>
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<td>--</td>
<td>Finan. access</td>
<td>Price</td>
<td>Price</td>
</tr>
</tbody>
</table>

* Donabedian's SPO Model  ** Martin's Model for Service Quality Measurement  ***Primary Care Assessment Survey Scale

(Responsive. – Responsiveness; Accommodat. – Accommodation; Communicat. – Communication; Problem solv. – Gracious problem solving; Organ. access – Organisational access to care; Contin. of care – Continuity of care; Interp. treatment – Interpersonal treatment; Knowl. of pt. – Knowledge of patient; Finan. access – Financial access to care; Physical evid. – Physical evidence)

Based on the review of literature and the comparative analysis as presented in the above table the dimensions of consumer satisfaction and healthcare quality that are being evaluated in the present study are:

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DIMENSIONS OF CONSUMER SATISFACTION AND HEALTHCARE QUALITY (PRESENT STUDY)

1. Medical outcome of care
2. Access to care
3. Responsiveness of the personnel
4. Empathy
5. Communication
6. Tangibles
7. Reliability of care
8. Price (cost) of services

The above 8 dimensions cover all aspects of marketing of healthcare services and all aspects of consumer satisfaction and quality of healthcare services.

REFERENCES


26. Supra note 17: 74.


32. Ibid.


35. Supra note 30.


52. Supra note 50.


82. Ibid: 1.


