CHAPTER II

REVIEW OF LITERATURE

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As a fundamental right, health services are of paramount importance. Patients are the consumers and have the absolute right to demand better services from hospitals. The dichotomous nature of India being a developing as well as technologically advanced country calls for marketing to play a distinct role of providing basic medical facilities with the help of state-of-art equipments and techniques by highly skilled doctors. The universal goal of the health care system is to ensure adequate access to quality care at a reasonable price. The present chapter, besides throwing light on developments in health sector in India, covers a review of literature on service quality, service quality models, dimensions of service quality, customer satisfaction, service quality and customer satisfaction and service quality and health services. The existing literature on the subject has been critically evaluated with a view to place in proper perspective the important contribution in the field, identify deficiencies and provide framework for future studies in the area of medical services.

2.1 Hospital Services in India

In India hospitals have existed from ancient days. Even in the 6th century B.C during the time of Budha, there were a number of hospitals to care for the crippled and the poor. The most outstanding early hospitals in India were those built by Ashoka (273—232 B.C.). Modern hospitals, however, came into operation in the 19th century (Timmappaya, 1967). After World War Second, India, including most developing countries started investing in the provision of
public health services as a part of their development plans as public health was
directly linked to human well-being and overall social and economic development
(Knowles, 1980; Mc Evers, 1980; Philps, 1990; Sen, 1996 and World Bank,
1980, 1994). As a result of this, India experienced a dramatic decline in the death rate
and an increase in the life expectancy (Census of India, 1991). The number of health
care services in India has increased since the beginning of the first Five year plan
in 1952 (Government of India, 1997). India is represented by various sectors and
agencies which differ from each other by health technology applied and the
source of funds for operation.

In 1981, a study group set up by the Indian Council of Social Sciences
Research (CSSR) and the Indian Council of Medical Research (ICMR) proposed
that the urban—biased, centralized, bureaucratic, over- professionalized and top-
down approach of the existing system be abandoned and that the new system of
health care services based on the community may be practiced (Benarji,1981).
Subsequently, India revised its National Health Policy in 1983 to reaffirm public
commitment to ‘Health for All’ by strengthening primary health care through
organized support from the community, voluntary agencies, paramedics, multi-
purpose workers and auxiliaries. The policy emphasized restructuring the health
services infrastructure, orientation of health manpower, improving the nutritional
level of low income populations, environmental protection, immunization
programmes for prevention of major communicable diseases, maternity and child
health services and extension of the school health programme (Benarji, 1990). At
present, the hospitals ceased to be merely an institution where the poor and
destitute were housed, but are transformed into a place for the promotion of
health, prevention of diseases, treatment of sufferings and teaching and research
in the health services. Primary Health Care is a new challenge to country’s
political leadership and an opportunity for service organizations and medical
professions to expedite execution of development plans (Bhatia, 1983). The
existing health system favors resource allocation to the minority of the population with ready access to hospital-based services and disease-specific problems (Benarji, 1981). Recent experiences of developed countries suggest that investment in decentralized population-based and health-services research aimed at the developing evidence-based health care, rather than the present emphasis in India on central, disease-based system could yield substantial health gains for the population (Tabish et al., 1998).

In the light of above discussions and as a background for the present study, some major studies on service quality, service quality Models, dimensions of service quality, customer satisfaction, service quality and customer satisfaction and service quality and health services are reviewed in this chapter.

2.2 Service

Services are intangible when compared to physical goods (Levitt, 1981). Bateson (1977) explained that there are two distinct characteristics of services, viz., ‘Palpable’ intangible, i.e. they cannot be touched; and ‘mental’ intangible i.e. it is hard to anticipate exactly the outcome of a particular service. Moreover, products are tangible objects that exist in both time and space, while services consist of social acts of interactions and exist in time only (Berry, 1980). Inseparability of production and consumption also stems from the concurrent creation and consumption that delineates the majority of services (Carmen and Eric, 1980; Gronroos, 1978; Zeithaml, et al, 1985 and Schneider and Brown, 1985). Goods are first produced, inventoried, sold, then consumed; services are usually sold first, then produced and consumed simultaneously because they cannot be inventoried (Berry, 1980 and Maister, 1982). Variability of service expectations is the hallmark of all the services, especially those with a very high labour content (Parasuraman, et al., 1985). The characteristics with the sum and substance of a service (e.g. medical examination, car rental and restaurant service) can vary from producer to producer, from customer to customer and from
day to day (Zeithaml, et al., 1985). Services are perishable, i.e. they cannot be saved and used later in times of need or emergency (Beason and Jackson, 1975 and Thomas, 1978). As services are performances that cannot be inventoried, services organizations are frequently in trouble in terms of matching supply and demand (Zeithaml, et al., 1985). Most services actually consist of acts and interactions, which are typically social events. The control and management of social events calls for certain special skills and techniques (Stebbing, 1993). Also, clients play a crucial role in influencing the outcome of the transformation process as well. Although the different models offered by various researches differ in the weights they assign to the several discriminating features of services, such as intangibility, simultaneously of production and consumption, variability of service expectation, perishability and participatory role of consumer, they all converge to one issue, i.e. if the prototypical service differs from the prototypical good, then the system by which these goods and services are produced and marketed will also vary.

2.2.1 Service Quality - Conceptualization and Operationalization

The attainment of quality in products and services has become a pivotal concern among the marketers in recent years. Quality has been reported as having apparent relationship to costs Crosby, 1979); excellence (Garvin, 1983); value (Cronin and Taylor, 1992); profitability (Buzzel and Gale, 1987 and Rust and Zahorik, 1993); customer satisfaction (Bolton and James, 1991a); customer retention (Reichheld and Sasser, 1990); behavioural intention and positive word-of-mouth. It is considered as the most important factor influencing the customer's buying decisions. Also, it has strategic benefits of contribution to market-share and return on investment (Anderson and Zeithmal, 1984 and Philips, et al., 1983) as well as in lowering manufacturing costs and improving productivity (Garvin, 1983).
While the quality in tangible goods has been described and measured considerably by researchers, quality in services, on the other hand, has largely remained much less researched. The reason being that service has a lot of intangible dimensions including reliability, responsiveness, competence, courtesy, friendliness, security, ambience etc, which are qualitative by nature and whose value is subjective. Service quality, thus, by its very nature is an elusive, indistinct and obstruct construct that is difficult to define and measure (Brown and Swartz, 1989). Customers do not easily articulate their requirements because there are difficulties in delimiting and measuring the concept. As a result, only a handful of researches have come a long way in operationalising the concept of service quality (Parasuraman et al., 1988; Brown and Swartz, 1989; Bolton and Drew, 1991a; Carman, 1990, Cronin and Taylor, 1992; Babakus and Boller, 1992 and Teas, 1993).

Different definitions of service quality have been put forth by the researchers over the time. Efforts in defining and measuring quality have come largely from the goods sector. According to the prevailing Japanese philosophy, quality is “zero defects-doing it right the first time”. Crosby (1979) defined quality as “conformation to Requirements”. Garvin (1983) measured quality by counting the incidence of “internal” failures (those observed before a product leaves the factory and “external” failures (those incurred in the field after a unit has been installed). Service quality however, has been discussed in only a handful of writings (Gronroos, 1982; Lehtinen and Lehtinen, 1982 and Lewis and Booms, 1983). Some have attempted to define service quality as zero defect—doing it right the first time with conformance to requirements (Reichheld and Sasser, 1990), while the others have explored the concept in terms of customer perception and expectation, customer satisfaction, customer attitude etc.

A definition of service quality by Parasuraman, et al., (1985) seemed particularly useful as it has been widely accepted by researchers examining the service quality issues. They defined service quality as: “the degree and direction
of discrepancy between consumers’ perceptions and expectations in terms of different but relatively important dimensions of the service quality which can affect their future behaviour”. In line with this thinking, Gronroos (1982) developed a model in which he contends that consumers compare the service they expect with perceptions of the service they receive in evaluating service quality. Also, Smith and Houston (1982) claimed that satisfaction with service is related to confirmation or disconfirmation of expectation. They based their research on the disconfirmation paradigm, which maintains that satisfaction is related to size and direction of the disconfirmation experience where disconfirmation is related to person’s initial expectations. Similarly Lewis and Booms (1983) definition of service quality clearly stated: “service quality is a measure of how well the service level delivered matches customer expectations. Delivering quality service means confirming to customer expectations on a consistent basis”. Examination of these above writings and other literature on service marketing suggested three underlying themes:

- Service quality is more difficult for the consumer to evaluate than goods quality.
- Service quality perception results from a comparison of consumer expectations with actual service performance.
- Quality evaluations are not made solely on the outcome of a service; they also involve evaluations of the process of service delivery.

From the above discussion it is clear that service quality revolves around customer expectations and their perceptions of service performance. Hence it is characterized by the customer perception of service and the customers are the sole judges of the quality. Parasuraman et al. (1991) rightly explained that consistent conformance to expectations begins with identifying and understanding customer expectations. Only then the effective service quality strategies can be developed.

In an effort to understand the concept of service quality, many proposed conceptual models are reviewed as follows:
2.3 Service Quality Model – Christian Gronroos (1982)

Gronroos (1982) developed a model which explains the 'missing service quality concepts' as shown in Figure 2.1.

Figure 2.1
Managing the Perceived Service Quality

According to this model, the total service quality is perceived by the customer as a comparison between the expected service, which he or she expects to get, and the perceived service, which the customer feels he or she has received. This means that provider of service will have to match the expected service and
the perceived service to each other, so that customer satisfaction is achieved. Clearly, the expectations are influenced by traditional marketing activities such as advertising, field selling, personal relations activities, sales promotion and pricing, and moreover, by previous contacts with the service, previously perceived services, as well as by tradition, ideology and word of mouth. On the other hand, the perceived service is only marginally influenced by traditional marketing activities. The contact with the service firm and its personnel, physical/technical resources and its other customers during the buyer-seller interaction are much more important. In the above interactions the service is rendered to the customer, and the service is perceived by him or her. According to the author, the service can be broken down into two quality dimensions, namely: technical quality and functional quality. These can also be described as two components of service image delivery as shown in Figure 2.2.
Technical Quality (What?)

It refers to what the customer is actually receiving from the service. This is quantifiable and capable of objective measurement, as with tangible goods. Moreover, it is influenced by technical solutions, the know-how staff, the computerized systems and other related machinery.

a) Functional Quality (How?)

It refers to how the technical quality elements of the service are transferred. It is influenced by the accessibility and appearance of the facilities, of long run consumer contacts, interrelations in the firm, and the attitudes, behaviors and service mildness of the contact personnel.

In short, the above described model of Gronroos focuses on the construct of image which represents the point at which a gap can occur between expected service and perceived service. He made the reader aware of the ways in which image is created from the aggregation of different aspects of technical and functional variables. By following this model of different inputs marketers were cautioned to the fact that they should not reduce quality to a simplistic description, but should try to understand the full range of inputs.

2.3.1. Service Quality Model—Parasuraman, Zeithaml and Berry Model (PZB Model)

The model suggested by Parasuraman et al. (1985) is depicted in Figure 2.3. The model attempts to show the salient activities of the service organization that influence the perception of quality. Moreover, the model shows the interaction between these activities and identifies the linkages between the key activities of the service organization or marketers, which are pertinent to the delivery of a satisfactory level of service quality. The links are described as gaps or discrepancies: that is to say, a gap represents a significant hurdle to achieve a satisfactory level of service quality. The gaps are described briefly below.
The central focus of the gap model is the **customer gap**, the difference between customer expectation and perceptions. Firms need to close this gap, that is, a gap between what customers expect and receive—in order to satisfy their customers and build long-term relationships with them. The model clearly indicates that customer's quality perceptions are influenced by a series of five distinct gaps occurring in an organisation. These gaps, on the service provider's
side, which can impede delivery of services, need to be closed. Thus, in total the model identified five gaps that can cause unsuccessful service delivery.

**Gap 1: Lack of Understanding (Gap between consumer expectation and management perception)**

This gap is the result of not knowing what consumers expect in service. Many reasons exist for manager not being aware of what customers expect. They may not interact directly with customers, be unwilling to ask about expectations, or be unprepared to address them. When people with the authority and responsibility for setting priorities do not fully understand customers' service expectations, they may trigger a chain of bad decisions and sub optimal resource allocations that result in perceptions of poor service quality.

**Gap 2: Lack of Development (Gap between management perception and service quality specification)**

The gap exists where managers are aware of customer expectations but the management might not simply be committed to implement what is necessary. This may be either through ignorance, lack of vision, limited resources, or adoption of a strategy such as harvesting where management is not concerned with the long term future. The management might not set quality standards or very clear ones or they may be clear but unrealistic.

**Gap 3: Poor Delivery (Gap between service quality specifications and service delivery)**

It is the gap that exists due to the discrepancy between development of customer-driven service standards and actual service performance by company employees. Even, the management understands the levels of service desired by the customers and specifies an appropriate set of standards. However, service delivery may not be of appropriate quality owing to poor employee—performance, since they are insufficiently trained. Indeed, the employees play a pivotal role in determining the quality of service.
Gap 4: Unrealistic Expectations (Gap between service delivery and external communication)

This gap illustrates the difference between service delivery and the service provider’s external communications. Promises made by a service company through its media advertising, sales force, and other communications and serve as the standard against which customer assess service quality. If the service standards are not met adequately it may lead to this type of gap.

Gap 5: Gap (Gap between expected service and perceived service)

This represents the difference in any given situation between expected and perceived quality while customer perceptions are subjective assessments of actual service experiences, customer expectations are the standards of, or reference points for, performance against which service experiences are compared. This gap can be the combination of the one or more of the previous gaps and provides a clear indication of the degree to which service quality exists in the service organization.

As already mentioned, among the service quality gap concept that has received the most attention is the “expected service-perceived service gap” (P-E) identified by Parasuraman, et al (1985), operationally defined in terms of a “perceptions-minus-expectations” measurement framework. Parasuraman, et al, (1988) defined perceived service quality as “a global judgment, or attribute, relating to the superiority of their service”. Additionally they link the concept of perceived service quality to the concept of perceptions and expectations as follows; “Perceived quality is viewed as the degree and direction of discrepancy between consumers perceptions and expectations”(Babakus and Boller, 1992). In the services marketing literature, perceptions (p) are defined as consumers’ beliefs concerning the service received (Parasuraman, et al, 1985) or experienced service (Brown and Swartz, 1989). Expectations (E) are defined by Parasuraman,
et al., 1988) as “desires or wants of customers, i.e., what they feel a service provider should offer rather than would offer”.

Thus, the operationalization of the quality concept in empirical studies suggests that perceived service quality can be conceptualized with the following P—E measurement model:

\[ SQ_i = \sum_{j=1}^{k} W_j(P_{ij} - E_{ij}) \]  

(1)

Where

- \( SQ_i \) = SERVQUAL overall perceived quality of stimulus i.
- \( k \) = the number of attributes
- \( W_j \) = A weighting factor if attributes have differentiated weights.
- \( P_{ij} \) = Performance perception of stimulus i with respect to attribute j
- \( E_{ij} \) = Service quality expectation for attribute j, that is, the relevant norm for stimulus i.

Equation 1 suggests that perceived service \( (SQ_i) \) increases as the difference between \( P_{ij} \) and \( E_{ij} \) increases across attributes. It is important to note that Parasuraman, et al. (1988) emphasize that this P-E service gap concept is different from the disconfirmed expectations concept in traditional consumer satisfaction/dissatisfaction models. First, the P-E gap concept represents a comparison with norm; it does not represent a difference between predicted and received service. Exceeding the norm means high quality is received and falling short of the norm means low quality is received. Second, the P-E service quality concept as expressed in equation 1 is not a predictive model. It is a measurement specification in which perceived quality is equivalent to perception—minus—expectations.

The traditional method of operationalising the P-E gap concept is to obtain perception and expectation scores for each attribute and calculate \( SQ_i \) by equation 1 with the attributes weights implicitly assumed to be equal \( (W_j = 1) \).
According to Parasuraman, et al. (1985); “the difference between the ratings of statements like these is a measure of perceived service quality. The higher (more positive) the perception-minus-expectation scores, the higher is the level of perceived service quality”.

2.3.2. Service Quality Model — Lovelock Christopher

Lovelock Christopher (1988), a leading authority on services, expanded Parasuraman, Zeithaml and Berry model to include two more gaps and thus offering total of seven gaps as shown in Figure 2.4. He explains the seven gaps as under:

**Gap 1:** is not knowing what your customers need and expect. This is really inexcusable. A logical response is to undertake research to find out.

**Gap 2:** is not using knowledge of customer needs and expectations as the basis for defining and specifying service standards. This is what is called “father knows best” phenomenon. Even if the kids tell you what they want, you ignore it and prescribe what you think will be good for them.

**Gap 3:** results when execution fails to match the predefined standards. This conformance problem and often reflects poor internal communications and lack of quality controls.

**Gap 4:** comes from the failure on the part of advertising and sales people to portray the service accurately in their communications to customers, most commonly they over promise. The problem could result from being poorly briefed about the service or from a tendency to exaggerate performance in order to capture customer interest. Excessive claims are just asking for trouble, since they raise customers’ expectations to heights that cannot be possibly met.

**Gap 5:** results when the customer misperceives the quality of service performance. One of the characteristics of good quality is that it is often
unobstructive. A customer may simply not realize the quality of work performed, especially with an infrequently used service such as health care, consulting or specialized repair work.

**Gap 6:** occurs when a customer misunderstands what a sales executive says or misinterprets the nature of advertising message and expects something different from what was actually promised.

**Figure 2.4**
*Lovell Christopher Service Model*

Gaps 7: occurs when the customer compares what he or she experienced with what was expected (additional expectations as modified by marketing communications).
2.3.3. **Service Quality Model—Haywood Farmer**

Haywood—Farmer (1988) argues that a service organization has "high quality" if it meets customer preferences and expectations consistently. The key element in the attainment of "high quality" is the identification of customers' service requirements and expectations. He suggested that the separation of attributes into groups is the first step towards the development of a service quality model. In general, services have three basic attributes: (a) physical facilities, processes and procedures, (b) people's behaviour and conviviality; and (c) professional judgment. Each attribute consists of several factors. In this model each set of attributes forms an apex of the triangle as shown in Figure 2.5. The management's task is to identify where the organization is located in this nexus. This will enable them to provide a service whose elements are internally consistent and focused on meeting the needs of a specific segment of the target market. In deciding the appropriate position of the service, management needs to consider three "operational" factors. These are (a) the degree of service customization; (b) the degree of labour intensity; and (c) the degree of contact an interaction. The model put forward by Haywood Farmer is helpful in terms of identifying the quality tradeoffs and the links between "quality" and "operational" factors. The model has the potential to enhance understanding but it does not offer a practical procedure capable of helping management to identify service quality problems or practical means of improving service quality. Figure also shows the likely position of several different organizations on this three-dimensional nexus. In the case of utilities, the important determinant of quality is the physical process; for example, reliability of facilities, capacity balance, control of flow, and timeliness. The behaviour of people is also important. All three elements are equally important in the case of a medical or design service. By identifying their organizations' position on the continuum, management will be able to implement more effective quality improvement processes.
Figure 2.5: Haywood Farmer Service Quality Model

Professional Judgment

Physical process

People behaviour

Physical facilities, process and procedures:
- Location, layout
- Size, decor
- Facility reliability
- Process flow, capacity balance, control of flow
- Process flexibility
- Timeliness, speed
- Range of service offered
- Communication

People's behaviour and conviviality:
- Timeliness, speed
- Communication (verbal, non-verbal)
- Warmth, friendliness, tact,
- Attitude, tone of voice
- Dress, neatness, politeness
- Attentiveness, Anticipation
- Handling complaints, solving problems

Professional judgment:
- Diagnosis
- Advice, guidance, innovation
- Honesty, confidentiality
- Flexibility, discretion
- Knowledge, skill

Key:
1) Short contact/interaction intensity — low customization, for example, utilities.
2) Medium contact/interaction intensity — low customization, for example, theme parks.
3) High contact/interaction intensity — low customization, for example, education.
4) Low contact/interaction intensity — high customization, for example, stock broking.
5) High contact/interaction intensity — high customization, for example, medical services

2.3.4. Service Quality Model — Beddowes et al. (1987)

The interpersonal behaviour of the service provider has an important influence on customers' perceptions of the quality of both "service process" and "service outcome". The model of service success developed by Beddowes et al. (1987) stresses the importance of behavioural considerations. The model is shown in Figure 2.6. According to this model, one of the most important quality success factors is the balance between customer and staff expectations.
Beddowes et al. argued that a common danger faced by many service organizations in inflating customer expectations through marketing efforts without balancing with what the organization can offer through appropriate development of staff and systems. According to this model, the other important contributor to service quality is the relevance and effectiveness of the service delivery system. The model identifies the factors that significantly influence service quality. It articulates why quality problems are likely to arise but not what the nature of these problems is and how to overcome them.

Without doubt, conceptual service quality models are useful so much as they provide and overview the factors which have the potential to influence the quality of the organization and its service offerings. These models stand as the major strands of the service quality improvement endeavors. These models are also useful for a number of reasons. First, they provide an over view of factors that affect the quality of the organization and its offerings. Second, they facilitate understanding. Third, they help to clarify how quality shortfalls develop. Fourth, they can provide a framework for launching quality improvement programmes. A framework has the advantage of channeling the efforts of the organization in the appropriate direction. The models reviewed above, however, do not represent the total picture. There are several other models given by researchers like (Bitran and Logo, (1993); Gronroos, (1984); Lewis, (1993) and Walker, (1990). Moreover, they are almost invariably simplified versions of reality. They can be misleading in the sense that tend to suggest that there are simple relationship between complex phenomenon, and that systems operate by rules of cause and effect.

However, human behaviour significantly affects the quality of an organization and its offerings, and this is more evident in service organizations.
Figure 2.6
Behavioural Service Quality Model

Service concept

External presentation: Marketing mix Communication mix

Internal operations: Staff Process systems

Balancing factor

Customer expectations

Staff expectations

Service delivery System

......The Crunch...

Experience

Loyalty
Profit
2.4 Dimensions of Service Quality

Service quality is not a singular but a multi-dimensional concept. The utility value of these dimensions however, is situation dependent. Sesser et al. (1928) listed seven service attributes, which they believed actually embrace the concept of service quality. These included: Security, Consistency, Attitude, Completeness, Condition and Availability. On the other hand, Gronroos (1988) identified five key determinants of service quality as: Professionalism And Skills (technical, outcome related); Reputation And Credibility (in age related); behaviour and attributes and accessibility and flexibility and reliability and trustworthiness (all functional, process related). Lehtinen and Lehtinen (1992) believed that service quality comprised of three dimensions. These they defined as the Physical Quality, Corporate Quality and Interactive Quality. They argued that in examining the determinants of quality, it is necessary to differentiate between quality associated with the process of service delivery and quality associated with the outcome of the service, judged by the consumer after the service has been performed.

Parasuraman et al. (1985, 1988) have conducted well-known studies to uncover key service quality attributes that significantly influence the customers' perception of overall service quality. They initially identified ten determinants of service quality based on a series of focus group interview sessions. These attributes were: Tangibility; Reliability; Responsiveness; Competency; courtesy; Communication; Credibility; Security; Access; and Understanding the customer. The research found a high degree of correlation between communication, competence, courtesy, credibility and security and between access and understanding and they combined them into broad dimensions of assurance and empathy, i.e. a total of five dimensions. These five dimensions are: Tangibility; Reliability; Responsiveness; Assurance; and Empathy.
Based on the above five dimensions, they developed SERVQUAL, a 22-item survey instrument for measuring service quality. Parasuraman et al. (1988) stated that although the relative importance of the categories would vary from one service industry to the next, it is believed that the determinants of service quality in most (if not all) consumer service industries are included in the list. These dimensions and the SERVQUAL instrument have been the subject of some criticism for measuring service quality (Albrecht and Zemke, 1985; Armistead, 1990 and Gronroos, 1990). Despite this criticism, these dimensions and the SERVQUAL instrument have formed the basis for a considerable amount of research and application in the field of service management.

A decade later, after Parasuraman et al. (1988), Berry et al. (1994) summarized their collective research with ten determinants of service quality:

- Listening to customers precedes action;
- Reliability is essential;
- Poor service quality is a system design problem, not an employee problem;
- Good service recovery can overcome poor service delivery;
- Service excellence includes both outcome and process;
- Customers want basic service;
- Customers expect fairness;
- Service takes teamwork;
- Employee feedback is vital to service improvement; and
- Leaders should serve employees.

Johnston et al. (1990) undertook some testing of the comprehensiveness of Parasuraman et al's by examining the service quality determinants in the light of empirical data gathered in ten UK service organizations. Their analysis, although generally supportive of the ten determinants, suggested a refined list of twelve. After further testing and development, the team provided eighteen
determinants of service quality. The list is probably the most comprehensive and detailed list of dimensions of service quality. These eighteen dimensions are:

1. Access;  
2. Aesthetics;  
3. Attentiveness/Helpfulness;  
4. Availability;  
5. Care;  
6. Cleanliness/Tidiness;  
7. Comfort;  
8. Commitment;  
9. Communication;  
10. Competence;  
11. Courtesy;  
12. Flexibility;  
13. Friendliness;  
14. Functionality;  
15. Integrity;  
16. Reliability;  
17. Responsiveness; and  

On a review of different definitions on service quality dimensions, it can safely be concluded that service quality is an umbrella construct with distinct dimensions, although, there is yet no real consensus as to the number of such dimensions.

2.5. Customer Satisfaction

Customer satisfaction has been defined in many ways by many researchers over the years. Oliver, (1996) holds the view that "Satisfaction is the consumer's fulfillment response. It is a judgment that a product or service feature or the product of service itself provided (or is providing) a pleasurable level of consumption—related fulfillment including levels of under-or over-fulfillment". According to this theory, consumers purchase goods and services with pre-purchase goods and services with pre-purchase expectations about anticipated performance. Once the product or service has been purchased and used, outcomes are compared against expectations. When outcome matches expectations, confirmation occurs. Disconfirmation occurs when there are differences between expectations and outcomes. Negative disconfirmation occurs when product/service performance is less than expected. Positive disconfirmation
occurs when product/service performance is better than consumer expectations, and dissatisfaction is caused by negative disconfirmation of consumer expectations.

Customer satisfaction can also be defined as satisfaction based on an outcome or a process. Vavra’s (1997) outcome definition of customer satisfaction characterizes satisfaction as the end—state resulting from the experience of consumption. This end state may be a cognitive state of reward, an emotional response to an experience or a comparison of rewards and costs to the anticipated consequences. Vavra also puts forth a definition of customer satisfaction based as a process, emphasizing the perceptual, evaluative and psychological processes contributing to customer satisfaction. In this definition, assessment of satisfaction is made during the service delivery process. Tse and Wilton (1998), however, are of the opinion that “satisfaction is the consumer’s response to the evaluation of the perceived discrepancy between prior expectations (or some other norm of performance) and the actual performance of the product as perceived after its consumption”. Similarly, Anderson and Sullivan (1993) suggested that “satisfaction can be broadly characterized as a post-purchase evaluation of product quality given pre-purchase expectation”. Churchill and Suprenant (1982) stated “customer satisfaction is an outcome of purchase and use resulting from the buyer’s comparison of the rewards and the costs of the purchase in relation to the anticipated consequences”.

The above definitions suggest that customer satisfaction is the feeling or of pleasure or disappointment resulting from comparing a product’s perceived performance (or outcome) in relation to his/her expectations. Customer satisfaction can be considered as the major outcome of marketing activity whereby it serves as a link between the various stages of consumer buying behaviour. For instance, if customers are satisfied with a particular service offering after its use, then they are likely to engage in repeat purchase and try
line extensions. Customer satisfaction is also widely recognized as a key influence in the formation of customer’s future purchase intentions. Satisfied customers are likely to tell others about their favorable experiences and, thus, engage in positive word of mouth advertising. Dissatisfied customers, on the other hand, are likely to switch brands and engage in negative word of mouth advertising. Furthermore, behaviours such as repeat purchase and word-of-mouth directly affect the viability and profitability of a firm.

Thus, customer satisfaction primarily focuses on the customer’s past and current evaluations of the product or service.

There can be potentially many antecedents of customer satisfaction as the dimensions underlying satisfaction judgments are general rather than specific (Tayler and Baker, 1994; Patterson and Johnson, 1993 and Rust and Oliver, 1994). Research on customer satisfaction has largely relied on the disconfirmation paradigm, which views satisfaction as a result of two cognitive variables: pre-purchase expectations and disconfirmation (Chuchill and Supernant, 1982; Oliver, 1989 and File and Prince, 1992). According to Peter* and Olson (1986), “Pre-purchase expectations are beliefs about anticipated performance of the product; disconfirmation refers to the differences between pre-purchase expectations and post-purchase perceptions”.

Hence, if the perceived performance exceeds a customer’s expectation (a positive disconfirmation), then the customer feels satisfied. On the other hand, if the perceived performance falls short of a customer’s expectations (a negative disconfirmation), then the customer feels dissatisfied. The disconfirmation model is shown in Figure 2.7.
Figure 2.7

Disconfirmation Model of Customer Satisfaction

Expected Performance (E)

Perceived Performance (P)

Comparison

P>E

Positive Disconfirmation

Satisfaction

Memorable will repeat buy

P=E

Confirmation

Neutral

Forgetful as options

P<E

Negative Confirmation

Dissatisfaction

Awful will not Repeat buy
There is a considerable amount of empirical evidence that confirms the disconfirmation paradigm (Szymaski and Henard, 2001). Churchill and Surprenant (1982) reported that disconfirmation positively affected satisfaction which means that when customers perceived the product performing better than expected they become more satisfied. Further, it has been also found empirically that satisfaction is caused by expectations and requires considerable cognitive effort on the part of customers (Bearden and Teel, 1983). However, other argued that customers develop norms for product performance based on general product experiences, and these, rather than expectations for a main brand’s performance, determine the confirmation/disconfirmation process (Cadotte et al., 1987). Research also demonstrated a direct link between actual performance and satisfaction level (Bolton and Drew, 1991). More recent work argued that satisfaction judgments are also dependent upon effective components as both coexist and make independent contribution to the satisfaction judgments (Mano and Oliver, 1993). Also, some have recently demonstrated a positive relationship between equity and satisfaction (Oliver, 1997).

2.6 Service Quality and Customer Satisfaction

In recent years, there has been a great deal of interest in the conceptualization and measurement of customer satisfaction and service quality by both managers and academic researchers. The concepts of customer satisfaction and service quality have been extensively researched, although many studies of consumer satisfaction have been conducted in service settings (Cadotte et al. 1987; Fornell, 1992; Oliver, 1980; Oliver and Swan, 1989 and Swan and Frederick, 1980). There seems to be a great deal of similarity between these two concepts yet researchers are usually careful to state that these are different constructs (Oliver and Wayne, 1988; Bitner, 1990; Boulding et al., 1993 and Carman, 1990).
A basic agreement emanating from the wide range of literature on service quality and customer satisfaction is that service quality and customer satisfaction are separate and unique constructs that share a close relationship (Anderson Fornell, 1994; Rust and Oliver, 1994 and Bitner and Hubbert, 1994). Although the distinction between quality and satisfaction is not very clear, customer satisfaction, as a cognitive and affective reaction, emerges as a response to a single or prolonged set of service encounters (Cronin and Taylor, 1992 and Oliver, 1993a). It is also argued that service quality is an overall attitude towards a service firm while as customer satisfaction is specific to an individual service encounter (Anderson and Fornell, 1994 and Rust and Oliver, 1994). Lacobucci et al. (1995) point out that key difference between service quality and customer satisfaction is the quality relates to managerial delivery of the service while satisfaction reflects customers’ experience with the service. Further, evidence has recently emerged that adds support for the distinction between the conceptual domains of service quality and customer satisfaction. Rust and Oliver (1994), based on Oliver (1993a), identified a number of key elements that distinguish service quality from customer satisfaction.

- Value judgments on service quality are evaluations of specific aspects or attributes, whereas judgments of satisfaction are more general;
- Expectations of service quality are based on perceptions of excellence whereas judgment of satisfaction include reference points such as needs or the fairness of treatment; and
- Judgments of perceived quality of a service are more cognitive, whereas judgments of satisfaction are more emotional reactions.

There are two agreements that surfaced from the growing body of literature related to customer satisfaction and service quality (Dabholkar, 1995). First, satisfaction and service quality are conceptually distinct but closely related constructs. Second, service quality is primarily a cognitive, left-brained, evaluate, objective concept while satisfaction is a combination of an affective, right-
brained, feelings-based, and subjective component with a cognitive, left-brained, evaluative, and objective component (Mano and Olver, 1993). Some researchers go a step further by arguing that the affective, feelings-based components of satisfaction are more important than the cognitive component (Jayanti, 1993; and Oliver, 1993a).

Another unresolved issue in the research of service quality whether customer satisfaction leads to service quality, or vise-versa i.e. the relationship between customer satisfaction and service quality has been extensively examined in the literature (Rust and Oliver, 1994; Bolton and Drew, 1994 and Lacobucci et al., 1995). Comparing two related constructs, Parasuraman et al. (1988) conceptualized perceived service quality as a long-run overall evaluation about a service, whereas satisfaction is a transition-specific evaluation. Based on these conceptualizations, they pointed out that incident of satisfaction over time results in perception of service quality. Other researchers also supported the argument that customer satisfaction leads to service quality. For example, Bitner (1990) developed a model of service encounter evaluation and empirically supported the effect of satisfaction on service quality. Bolton and Drew (1991a) also proposed that satisfaction leads to service quality. In contrast to this perceptive, some other researchers argued and empirically supported that perceived service quality is an antecedent of customer satisfaction. Several other approaches consider service quality as an antecedent to customer satisfaction, since satisfaction depends on pre-existing or contemporaneous attitudes about service quality (Parasuraman et al., 1988; Rust and Oliver, 1994; Dick, 1994 and Oliver, 1993a).

Spreng and Mackoy (1996) also studied the relationship between service quality and satisfaction based on their modified Oliver's (1993) satisfaction/service quality model. Their model fitted the data well where service quality was hypothesized to influence satisfaction. In their study, the path coefficient between the two constructs appeared to be significant (t = 9.4). According to
Aeker and Jacobson (1994) perceived quality provides a measure of the customers' global assessment of the superiority or excellence of a product and is correlated to organizational performance. Quality is, therefore, viewed as one dimension of satisfaction. The concept of product and service quality is intricately linked with the concept of customer satisfaction. As stated by Macbeth and Ferguson (1994), "Total customer satisfaction and delight is what Total Quality is all about". Evans and Laskin (1994) in their study concluded that if a firm understands expectations, builds partnerships, empowers employees, and embraces total quality management, four positive outcomes will occur: customer satisfaction, customer loyalty, quality products and higher profits.

Although an extensive review of this dispute is neither the aim nor the intention of the current research, the researcher of the present study wish to establish a basis for the present contention that service quality influences, among other things, levels of customer satisfaction, that is, we maintain the position that service quality as determined by its various components – is a partial determinant of satisfaction. There exists numerous empirical works to support quality/satisfaction casual order.

Hence, many attempted to establish the nature of the relationship between service quality and customer satisfaction. Some have proposed a casual link between customer satisfaction and service quality, due to the fact that satisfaction is viewed as experiential or occurring at the transaction level, whereas, service quality is viewed to be an attitude at a global level (Sivadas and Baker, 2000 and Bitner, 1990). However, the current research follows a substantial amount of research, which has proposed a casual link between service quality and customer satisfaction. This is due to the fact that customers can and do evaluate service quality at the transactional level and customers satisfaction may be quite meaningful at the global level (Oliver, 1993a; Anderson and Sullivan, 1993 and Woodside et al., 1989).
2.7 Service Quality and Health Services

The application of quality-management practices by manufacturers and service providers has become increasingly widespread. Recognition of the differences between goods and services like intangibility, inseparability, and heterogeneity of service products (Buttle, 1996; Berry and Parasuraman, 1991; Zeithaml et al., 1990) has enabled quality-management practitioners to develop approaches that have proved effective in improving service quality. The quality of service – both technical and functional – is a key ingredient in the success of service organizations (Gronroos, 1984). Technical quality in health care is defined primarily on the basis of the technical accuracy of the diagnosis and procedures. Several techniques for measuring technical quality have been proposed and are currently in use in health-care organizations. Information relating to this is not generally available to the public and remains within the purview of health-care professionals and administrators (Bopp, 1990). Functional quality, in contrast, relates to the manner of delivery of health-care services. With competitive pressures and the increasing necessity to deliver patient satisfaction, the elements of quality control, quality of service, and effectiveness of medical treatment have become more important (Friedenberg, 1997). Several studies have (Butler et al., 1996, Kandampully, 1997 and Strasser et al., 1995) proposed that significant variation exists between patient expectation of treatment quality and the perceived service quality of the treatment received, and that this is due to a number of factors related to the service quality of the treatment delivered.

Several studies indicate that a lower priority is placed on patients’ non-clinical expectation of service quality. Carson et al. (1998) have stated that some professionals contend that customers’ perception of quality service in health care is distorted due to the inability of patients to judge the technical competence of the medical practitioner with any accuracy. John (1996) believes that medical
courses cover technical details and knowledge in detail but expect students to develop customer-service skills as they become more experienced. The focus of the medical practitioner on technical prowess and knowledge is understandable, given the highly complex nature of the profession and the immense resources that are devoted to the education and training of doctors (Baldwin et al., 2002).

The above discussion on the subject, service quality and health services, leads to the conclusion that as patients are often unable to assess the technical quality of medical services accurately, functional quality, therefore, becomes primary determinant of patients’ perceptions of quality. This perceived quality is the single most important variable influencing consumers’ perceptions of value and affects their future intention to purchase such services.

2.8 Research Gaps and the Agenda for Future Research

The above review highlights some important studies on service quality, customer satisfaction and hospital services and brings to light the gaps and deficiencies in the respective areas. It conveys that in developed countries a good deal of effort has already been made to study a large number of problems associated with service quality. In India, unfortunately, very little attention has been paid to study such problems. This may be due to the fact that services marketing in general and service quality in particular, till recently, was not recognized as an area of significance in the socio-economic requirements of our country. Most of the existing studies are by their nature, general and descriptive and lack empirical evidence. With a view to study service quality, with an objective and analytical approach, all the problems inhibiting the growth of research in the field will have first to be looked into.

Services marketing in general and service quality in particular cannot be adequately comprehended without due reference to Babakus and Boller, Bolten and Drew, Carman, Brown and Swartz, Carson and Gilmore, Gronroos, Lehtinan
and Lehtinan, Parasuraman, *et al.*, and Zeithaml and Berry. The roots of the service quality lie in early conceptual framework from Europe (e.g. Gronroos, 1983; Lehtinan and Lehtinan, 1992). Most of the recent work on service quality in marketing can be credited to the pioneering and continuing contribution of A. Parasuraman, Leonard Berry and Valarie Zeithaml.

In a liberalized environment, an analysis of service quality in hospitals has a vital significance, but in India, unfortunately, it was almost left out of in-depth analysis. The dynamic process of development coupled with structural, financial and technological changes have given birth to stiff competition not only from hospitals but also from non-hospital institutions. In view of these developments, there is a need to study quality of existing and new patient services, hospital patient relationship, service technology and various other issues so as to meet growing needs of patients or customers and health officials. These are immediate tasks awaiting further in-depth study and research.

Very little effort has so far been made to assess and develop the concepts, research methods and procedures used in research on service quality. The present methods of assessing service quality in hospitals is quite unsatisfactory as most of the research is descriptive in nature and deals with the problems of patients, the extent of patient satisfaction, indifference of staff towards patients etc. Other vital issues such as physical facilities available in a hospital, convenient registration and admission procedure, treatment procedure, hospital patient relationship, service delivery, friendly staff, food services, cleanliness and comfort, physician care, nursing care which have direct bearing on service quality have rarely been touched with any empirical evidence. This calls for well-organized research and documentation centers, which are indispensable for the growth of health services marketing.
In conclusion, with a view to strengthen the analytical framework for studies in service quality, it is desirable to concentrate the research efforts in the above-mentioned areas. In addition to these significant areas of research, the following are the other fruitful and revealing areas of research as time is over due to focus attention on them.

1. The forces of deregulation, technology and customer care are broadly likely to have an impact on health care marketing. There is a need to study how technology can help to bring efficiency in health culture, to retain existing customers and how can it be helpful in increasing patient output and patient services.

2. Developing consistently a good service quality is difficult but profitable for service organizations. Customer service centers around two important aspects, viz., designating of a service and delivery of service. Both aspects are equally important, because delivery of a perfectly designed service is as harmful as perfect delivery of a badly designed service. There is a need to identify and investigate those potential factors which affect the delivery of quality service.

3. Service firms face many critical problems as they differ in intangibility, inseparability, perishability and heterogeneity from goods firms. What are these problems? How are they changing due to environmental, competitive, and other conditions? The services marketing research needs to focus on the most critical problems facing service firms if it is to be of maximum value.

4. Fluctuation of demand in service organizations is the most troublesome issue and seems to be the most fertile area for future research.
5. Relationship marketing, an emerging concept, is gaining wider acceptability in service organizations. The cost of maintaining existing relationship compared to developing of new customers needs a fresh look to reveal the benefits of relationship marketing.

6. Relationship between productivity, quality, cost reduction, technology, overall socio-economic development and health services.

7. Evolving a system of health services marketing based on trust, openness of communication, word of mouth communication that is critical, as services are intangible and heterogeneous in nature and participative involvement of parties.

8. The employees are in many senses an important part of service product. They represent the fifth ‘p’ in the services marketing mix. Therefore, there is a need to study/investigate internal marketing because their participation and role is recognized as being critical to levels of service quality and service delivery.