CHAPTER V

SUMMARY AND CONCLUSIONS

5.1 Introduction

This chapter concludes the work done and hence the research document, and lays down the limitations of the work done as also highlights the further research opportunities towards a follow-up research.

5.2 Summary

Concept
The whole conceptualization of this research topic was a bye product of personal experiences at some of the Government and the so called Charitable Hospitals. Having taken the gauntlet there was no option of going back in spite of the warnings by friends, specialists like CRMGuru and the lack of research in this area.

Healthcare marketing primarily being a service marketing concept, Relationships are very important. Relationship Marketing is a marketing method in which businesses consistently maintain two-way communication with their prospective, current and inactive customers in order to gain a deeper understanding of their needs while delivering personal and compelling marketing throughout their lifecycle.
Research in relationship behavior and relationship marketing has presented a lot of strong evidence that supports the hypothesis that the relationship aspect plays a central role in the understanding of markets and company behavior in real life. This research not only draws such conclusions from empirical evidence, but also from theoretical models of behavior and marketing systems that can actually describe and explain relationship patterns and market structures (Hougaard and Bjerre 2004 14).

Given the dramatic effect that improved customer retention can have on business profitability, the hospitals need an approach that leads to greater loyalty, enhanced relation and profitability. This in turn requires them to better understand how to measure customer retention; identification of root causes of defection and related key service issues; and the development of corrective action to improve retention. While the Healthcare sector is very broad and consists of many segments we are restricting this study to Hospitals only.

The setting up of the Corporate Hospitals, although still at the nascent stage in India, was preceded by the Charitable Hospitals phase. The healthcare scenario had otherwise been occupied wholly by the Government Sector except for the private clinics. Now, the situation has reversed wherein the Government investments in the Hospitals is very less, barely to the extent of 20% of the total expenditure on health in India. Although, on the whole for an Asian comparison the Health expenditure as % of GDP for India is a healthy 5% + and is only second to China. In India healthcare is about to explode: the sector, comprising sectors like hospitals, health insurance, and managed care is worth $15 billion translating to Rs. 670 billion currently (that's almost equal to the turnover of the country's 12 largest private sector companies including Reliance Industries, Hindustan Lever and ITC).
Objectives
The relevance of the research is both from industry and academic viewpoints.
The objectives of this research are:

- To ascertain the Customer Service Quality perceptions vis-à-vis the expectations.

The research sub objectives to attain the main objective are:

- To understand the service standards maintenance thru responsiveness, reliability and assurance.
- To understand the convenience, empathy and tangibles delivery against the expectations.

This study is descriptive in nature and conducted in phases. The first phase deals with developing an appropriate research framework with facts and theories accessed from literature survey on Healthcare sector, Healthcare sector Analysis, and the current pattern of Customer Relation practices in the Healthcare sector. The aim is to develop the framework, which will then be used to serve meeting the research objective and sub objectives. The second phase of the study will be an empirical study of Hospitals through the beneficiaries. The research approach includes Survey Research, through structured questionnaire and Interviews. The standardized and validated questionnaire after due pilot testing and suitable changes, if any, are used.

Questionnaire and Data Collection
A structured questionnaire was developed to collect data on the variables in this study. The questionnaire was adapted from the famed Service Quality: SERVQUAL (Parasuraman, Zeithaml, and Berry 1986, 1988); Ethics: Corporate Ethics Scale: CEP (Hunt, Wood, and Chonko 1989); Ethics: Marketing Norms Ethics Scale (Vitell, Rallapalli and Singhapakdi 1993) and Customer Orientation (Deshpande, Farley, and Webster 1993). A modified SERVQUAL questionnaire
relevant to the healthcare industry was constructed by including items from the original five dimensions (Tangibles, Reliability, Responsiveness, Empathy and Assurance) of the SERVQUAL instrument developed and updated by (Parasuraman, ZeithamI, and Berry 1986, 1988). Cronin and Taylor (1992) test several service quality models, as well as the relationships among service quality, satisfaction, attitude, and purchase intentions. Their research supports measuring service quality as a unidimensional, performance-based construct called SERVPERF, which is equivalent to the 22 PERCEPTION items of the original SERVQUAL measure. The items were refined and paraphrased in both wording and contextual application as appropriate to suit research purposes. We received responses from 406 respondents and the number is sufficient even at maximum variability and 95% level of confidence.

Data Analysis
The reliability of the data was ascertained before any analysis was taken up so as to make sure about its utility for analysis. This was followed by a demographic analysis of the sample. The sample is almost perfectly balanced in terms of Gender and inpatients/outpatients although there is a minor skew of 3% towards outpatients. The gender representation from urban populace is equally divided while females form less than 34 percent of the rural sample. Likewise less than 34 percent of rural sample were inpatients. The Hospitals attracted most patients from their respective super specializations, e.g., Escorts, Max and Apollo for Cardiology; Pushpawati for Renal, hepatic and Stomach; and Fortis, Modi for General patients (mostly outpatients). More than 60 percent inpatients were cardiology cases while majority of outpatients were from general or other ailments.

Findings
The Hospitals attracted most patients from their respective super specializations, e.g., Escorts, Max and Apollo for Cardiology; Pushpawati for Renal, hepatic and Stomach; and Fortis, Modi for General patients (mostly outpatients). More than
60 percent inpatients were cardiology cases while majority of outpatients were from general or other ailments. The correlation coefficients in the above tables are all in the significant zone at 99% confidence level and hence ready for Factor analysis.

The hospital services overall as also for each of the variables were found to be short of the expectations, although to a varying degree. The aspect has been discussed in details identifying the variables and the expectation perception gaps respectively. The hospitals have been rated in accordance with the responses from the respondents.

5.3 Conclusion and Recommendations

Service Quality is “the degree of discrepancy between customers’ normative expectations for the service, and their perceptions of the service performance.”

- Reliability, (dependability, accuracy)
- Responsiveness, (prompt, with staff showing a willingness to help),
- Assurance, (knowledgeable and courteous employees, who convey trust and confidence)
- Empathy, (caring and individual attention);
- Tangibles, (equipment, cleanliness), and
- Convenience, (location, navigational guidance)

Babakus and Mangold determined that SERVQUAL is reliable and valid in the hospital environment, but also raised questions about the need to measure expectations.

The corporate hospitals here are not meeting the standards as expected by the patients on all the fronts although, by varying degree.
The Service Performance being not upto the Service Quality levels desired by the patients, the hospitals have got to get their act together. The Corporate Hospitals must act in all the seriousness to plug the gaps and excel on the respective parameters.
Providers consider increasing quality in health care to be “the right thing to do”.

The revival of customer service occurred, in part, because service quality, as opposed to cost, distinguishes among health care institutions (Hudson 1998). Secondly, involvement and satisfaction of the customer affect behavior. Legnick-Hall (1997) developed a conceptual model of the consumer contribution to quality, which includes a description of the relationship of perceived quality to satisfaction, and the motivation to change behavior. This is of considerable importance if you consider the relationship between patient satisfaction and compliance with medical treatment plans. Researchers found a positive relationship between the patients’ feeling of satisfaction and compliance with respective medical regimes (Harris, et al 1995) (Drug Topics 1998) (Salimbene 1999). Third, as quality improves, expectations increase. According to Moore and Berry, as consumers become more quality conscious, service firms not only need to satisfy their expectations, but to exceed them (Moore et al 1994) (Berry et al 1988).

The consequence of NOT meeting expectations received some attention. Researchers identify managing negative reactions, which come from unmet expectations, as a strategic method for ensuring patient satisfaction. Not to do so, is to lose market share and customer loyalty. (Mittal 1996 and Zifko-Baliga 1997). Dube and Menon (1998) conducted further research on the relationship of negative emotions to reduced satisfaction. Leaders in the health care industry, therefore, need to anticipate patient expectations, then develop health care services that will exceed them (Sherden 1998).
The more pragmatic argument relates quality to increased market share and a stronger competitive edge. Shetty (1987) maintains that quality can advance profitability by reducing costs and improving a company’s competitive position. Within the health care industry, competitive advantage is best attained through service quality and customer satisfaction in the minds of customers (Taylor 1994). Woodside, et al, (1989) provided support for service quality influencing service provider choice.

The following is the hospital comparison in terms of the analysis of the collected information:

**BEST**

- Escorts Heart Institute and Research Centre is the best in terms of Tangibility, Convenience and Responsiveness implying that it has the least of difference between the expectations and perceptions.

- Indraprastha Apollo Hospital is the best in Assurance, Empathy and Reliability attributes.

- The Highest of the values all across the perception and expectation values across the factors is for Tangibility at Escorts.

- The Second Highest value all across the perception and expectation values across the factors is for Convenience at Escorts.

- The best performance is exhibited for Convenience and Tangibility.

**WORST**

- Fortis Jessa Ram Hospital is the worst in Responsiveness and Empathy.
- Pushpawati Singhania Hospital is the worst in Assurance.
- Max Devki Devi Hospital is the worst in Tangibility.
- Modi Hospital is the worst in Reliability and Convenience.
- The poorest performance is exhibited in Responsiveness and Reliability.
- The Lowest value across the factors is for Reliability at Modi Hospital.
- Second Lowest value across the factors is for Responsiveness at Fortis Jessa Ram Hospital.

Hence the Competitive advantage can be claimed and further improved upon by Escorts Heart Institute and Research Centre and Indraprastha Apollo Hospital while furthering their performance for the other factors. Fortis Jessa Ram Hospital and Modi Hospital have considerable efforts to put in even to close their gap with Escorts and Apollo. Singhania Hospital and Max Hospital are more middle of the road hospitals and require lesser strategy and plans to catch up with the top hospitals.

India's corporate hospitals need to be fully equipped, up market and efficient. With their toll-free helplines, interactive websites, online quotes and time-bound treatment access, they can appear to be a world apart from the overburdened, often badly managed and poorly funded public health system.

Just three major corporate hospital groups, Fortis Healthcare, Wockhardt and Apollo Hospitals run 26 hospitals in the subcontinent and that number is growing. They are forming partnerships with international insurance and tourism companies that will send both insured and uninsured patients for low cost
treatment. This will boost their image globally since most of them already have the coveted global accreditations.

Joint Commission International, a benchmarking body lists Indraprastha Apollo, New Delhi, and Wockhardt, Mumbai, as accredited hospitals. Accreditation apparently brings immediate benefits. "There has been a steady increase in the number of patients over the last six to eight months, particularly from the U.K. and U.S. The numbers have been increasing after accreditation, particularly from the U.S.," says Vishal Bali, chief executive officer of Wockhardt.

It is also important to have systems that meet the criteria of insurance companies. Says cardiac surgeon V.V. Bashi of MIOT Hospital, Chennai: "Our medical standards are world class, but if we have to get more patients from the U.S. and other developed countries, we must match their hospital documentation standards. This is really important because the insurance companies must cover all the risks in the event of an adverse treatment outcome."

Wockhardt's hospital in Bangalore, which has a Harvard Medical International tie-up, gets half of its foreign patients (about 900), from the U.K. The media reported the story of one such patient with coronary heart disease, 73-year old George Marshall last year. This violin repairer from Bradford was operated upon at the hospital for a quarter of what he would have paid for private care in the UK, including the airfare.

When he arrived in India, he was initially shocked by the traffic chaos and urban squalor, but it appeared to be a better decision than having to suffer a long delay for bypass surgery in a state-supported National Health Service hospital or fork out GBP £19,000 for immediate private care in his home country.

Another 35 per cent of Wockhardt's patients come to Bangalore from the U.S. and the rest from the European Union and South East Asia. Another heart care
institution in Bangalore, Narayana Hrudayalaya, has a record of 15,000 surgeries performed on patients from 25 foreign countries, half of them children.

With some friendly policies from the Government, the private healthcare sector can transform the potential of medical tourism into a very profitable reality. Stories of foreign nationals undergoing complicated surgery in the country are frequently featured in the media. Those who come now are not just from other developing countries (the first lady of Guyana brought a group of 15 patients for cardiac treatment to Frontier Lifeline hospital in Chennai), but also from the United Kingdom, Europe and North America. Tanzania and Iraq have a Memorandum of Understanding with the Madras Medical Mission.

Many opt to undergo surgery in India for reasons that range from long waiting times in the U.K., high costs or lack of insurance cover in the U.S., to plain lack of expertise in many Asian, African and West Asian countries. This needs to be further augmented and the point must be communicated across efficiently and clearly to the global market for the best scenario. Although, it is a big question if all this will make the facilities unaffordable and out of bounds, in terms of waiting time, for the domestic population. Yet, one thing is for sure that the positive rub-offs will exceed the limitations and healthcare will become an effective and steadily growing sector with attraction of market entry for other players or for expansion of the network.

The CII-McKinsey report says that the allopathic system can offer treatment in specialities such as cardiac, liver, renal and orthopaedic procedures, while Indian systems of medicine could attract patients from even the developed world to treat "lifestyle diseases" such as stress and rheumatism. Many visitors who come for such de-stressing and health-building treatment may also choose to visit tourist spots. Such tourism potential holds the key to Kerala's plans. The Ayurveda State has declared 2006 the year of medical tourism and is actively supporting its
well-known traditional medicine and tourism sectors, as they reach out to more potential visitors.

Elsewhere, development plans, both State-led and in the private sector are being pursued actively: Karnataka, which gets about 8,000 patients a year and forecasts an annual growth rate of 25 per cent, will promote a massive health park near a new international airport in Bangalore; non-resident Indians have formed a medical tourism company in Vadodara and international property developers are venturing into the healthcare sector to participate in the construction boom. In Maharashtra, the State Government is part of the Medical Tourism Council that has members from Association of Hospitals and FICCI.

In New Delhi, Naresh Trehan, executive director of the Escorts Heart Institute and Research Centre has proposed a Medicity on the outskirts of the capital to develop a 1,500-bed healthcare centre of international standards with 20 super specialities. It will incorporate traditional medicine too and have such facilities as hotels, serviced apartments, clinical and biotechnology laboratories.

Ventures such as these draw encouragement from the National Health Policy 2002, which endorses provision of health services "on a payment basis to service seekers from overseas". The corporate healthcare sector views such support as critical, considering that it is competing with Thailand, Singapore, Malaysia and South Korea for a bigger share of Asia's medical tourism market. "Medical tourism can be a much bigger business, if we have infrastructure and networking among hospitals, hotels and tourism agencies. The Central and State governments must extend tax and other concessions, on the lines available to IT and BPO sectors," says K. Ravindranath, managing director, Global Hospitals, Hyderabad. He readily favours cross subsidy for domestic patients from revenues flowing out of medical tourism.
Private hospitals in Hyderabad, some of which get 10 per cent of their patients from abroad, are planning to open separate wards or wings for foreigners. The Apollo Hospitals already has a ward and wants to upgrade it to an international multi-speciality block while the Asian Institute of Gastroenterology plans to create a separate wing for foreigners.

Figures for patient arrivals from abroad are available from individual states and hospitals: The Karnataka Tourism Department says it has been receiving about 8,000 patients annually, mostly for cardiac and orthopaedic procedures. Manipal gets 3,000 foreign patients a year, some of them for dental care; Wockhardt Hospital and Heart Foundation in Bangalore gets 900 patients a year.

The biggest disincentive to medical tourism, the hospitals say, is the insensitive handling of visa issuance to those who come for treatment. While people-to-people relations are strengthened when a patient from Pakistan, Iraq or Afghanistan gets operated upon in India, the requirement that visitors must report to designated officials periodically is viewed as avoidable harassment. "The patients get dejected, though they are grateful to the doctor, hospital and host country for saving their lives," says Dr. Bashi.

Strong emotional bonds can indeed be built by treating patients from other nations, says urologist Sunil Shroff of Sri Ramachandra Medical College and Research Institute, who has led a campaign for ethical transplants and altruistic organ donation in India through the MOHAN Foundation. "Medical tourism needs a national task force that will bring hospitals and the government together. We must ensure that a health divide is not created within the country and yet use this huge opportunity," he says.

The corporate hospitals have not failed to recognise the opportunity. Many of them are upgrading to offer the latest medical diagnostic facilities to medical tourists, which may also be packaged with vacations in a tie-up with airline
companies. Says Anil Maini, president, corporate development, Indraprastha Apollo, "We have 64 slice CT scans, PET CT and 3 TELSA MRI machines which most hospitals abroad cannot boast of."

But as corporate hospitals open their doors to a greater number of medical tourists, some analysts believe that the impact of this phenomenon on national healthcare needs careful study. Some observers fear an exodus of highly skilled doctors from the atrophied public health system to high paying private hospitals. "Many States are not even ready to fill vacancies in government medical service, compounding the problem," says a surgeon in Chennai's Government General Hospital, the apex public health institution in Tamil Nadu.

5.4 Limitations of this study

- The study is geographically limited in its scope since it covers only the Metropolitan Delhi. The response to the mailed questionnaires was rather poor limiting the whole exercise.

- Since the responses were from Delhi only one of the most important aspects missed was the response from the rural masses since they hold the key to the future of these hospitals.

- The cross comparisons between the Government Hospitals, Charitable Hospitals, Corporate Hospitals and the Diagnostic set ups is lacking since the scope of the study was limited to Corporate Hospitals only.

- The mental state of the inpatients and their attendants, in view of their miseries, does not allow them to respond to the questionnaire as rationally as is desirable in the said exercise. At times the responses are led by more of feelings than the truth. Moreover, the response basis is very subjective and hence introduces bias in the exercise, although,
some bit of it is eliminated on account of Before-After kind of the questionnaires. This mostly evens out the bias.

- Corporate hospitals are at a nascent stage. There is a distinct evolution of corporate hospitals from the charitable, private and Government hospitals. Most of the hospitals are barely one to two years old and are yet to be out of their respective teething problems. The management led stable strategies normally start taking effect only after 3 to 4 years of successful existence of the Hospitals.

- The Doctors' and staff interviews could have given the Human Resources perspective too. This could have given useful insight into their thought process and the value system and hence the management perspective on the whole.

- The Credence issues are not addressed in absolute sense. These are attributes that can be discerned only after the product or service is purchased or consumed. Credence properties are at the end of the spectrum and are often difficult, if not impossible for consumers to evaluate. Since many service encounters contain many credence properties, consumers often have difficulty finding attributes on which to base the experience. As a result, consumers evaluate the process, based on predetermined scripts, as well as a reaction to the service provider, again, based on a set of scripts. The typical model of consumer satisfaction, that satisfaction is the result of expectations, performance, and disconfirmation, may not be applicable to the health care setting. Health care services in general contain high credence properties, making it difficult for consumers to develop expectations prior to receiving service. While these individuals may not have a defined set of expectations regarding their care, they generally have an idea of the process that takes place, and therefore are able to judge
whether the service is being provided at a satisfactory level. Hence, the credence properties are not clearly identifiable and hence very difficult to measure.

- The provider-consumer interaction is more intense, and can at times have Life and death consequences and hence this aspect too is important to be covered.

- The repeat buying behavior has not been explored. Although, generally undesirable feature in terms of the Hospital care, the repeat buying behavior is an important aspect in terms of the outpatients. This can reflect upon the continued faith on the Hospital and hence the patient satisfaction with the whole experience. On the other hand, this can also raise questions about the effectiveness of the treatment as such and the quality of healthcare besides the Doctors’ competence.

### 5.5 Areas for future research

- Extensive national study to compare the hospitals on each specialty. The needs against each of the specialties are different and hence require segregated treatment.

- The cross comparisons between the Government Hospitals, Charitable Hospitals, Corporate Hospitals and the Diagnostic set ups can give a detailed and clear cut insight into the basic differences and the respective points of weaknesses and the strengths.

- A cross country study, especially the Asia-pacific region, between the different factors and variables can help in understanding the basic paradigms and hence enable in realizing the specific strengths and weaknesses.
• Study of training initiatives, appraisal systems and the customer centric initiatives from the top management. Interview of Doctors, staff, vendors and suppliers for 360 degrees knowledge and relevant results. This can lead us to the organizational mindset towards the complete scheme of things.

• The qualitative fact with respect to the quantitative details of medical tourism. This aspect has become critical both to the Indian economy and the Indian healthcare system (in terms of costs, new corporate hospitals entry, quality of care and the competence of Doctors).

• Corporate Social Responsibility Initiatives by the hospital. This will help in judging the hospital on its efforts towards not just individuals but about the society on the whole. The hospitals have a major role to play in bringing about the social equalization and well-being.

• Benchmarking of critical services in Hospitals is extremely useful in deciding the comparative ratings of the hospitals, thereby, recognizing and promoting excellence and also to present the achievement yardstick for the hospitals which are lagging behind.

• Patient satisfaction has been connected with health care utilization too, although there is disagreement among researchers regarding this relationship. For example, Roghmann et al. (1979) studied the impact of satisfaction on health clinic utilization levels of mothers receiving Medicaid, and results indicated that satisfaction with clinics was positively associated with utilization. Mirowsky and Ross (1983) found that satisfaction with physicians increases physician visits, which, in turn, decreases satisfaction. Still others have found no relationship between satisfaction and health care utilization. Kolodinsky (1995) examined consumer satisfaction with primary care physicians in
managed care health plans. Results indicate that there does not exist a
simultaneous relationship between use of physicians' services and
satisfaction. The contradictory findings from researchers provide the
motivation for continued research into this topic.

- The credence issues in healthcare need to be examined on a holistic
basis so as to delineate the same from the other factors and present an
integrated model to examine the patient satisfaction levels.

- The success rate in terms of the minimal post procedure mortality rates
also need to be examined for the critical cases.

- While satisfaction and quality are different concepts, a relation between
the two has been identified. Incidents of satisfaction, over time, result in
perceptions of quality in services (Rodwin 1994). This relationship,
however, has not been widely tested empirically. The literature on
satisfaction, particularly patient satisfaction, shows that satisfaction
ratings are derived from satisfaction with various components of their
care, and that consumers are able to make summary judgments
regarding their care. Similarly, quality is a multidimensional concept.
Donabedian's (1980) structure, process, and outcome is more
applicable to traditional health care settings, while SERVQUAL
proposed by Berry, Zeithaml, and Parasuraman's (Parasuraman,
Zeithaml, and Berry, 1985; 1994) captures quality in long-term care
more effectively. Both the satisfaction and quality literature has divided
researchers on a number of issues (e.g., the use of consumers'
evaluations of health care, and the relationship between satisfaction
and health care utilization), which provides impetus for further research
into these areas.