An Empirical Investigation In Delivering Quality Healthcare Services To Patients

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INTRODUCTION

Healthcare is a fast-growing sector, which is developing at a very fast pace. People are becoming health conscious and are demanding better quality healthcare measures. Huge investment is being made in research and development (R &D), this has led to development of new and better life-saving drugs and equipments. Earlier, many diseases did not have any cure for them, but today, such diseases have no longer remained a big threat to mankind. The implementation of newer and better technology in hospitals has helped to save many lives, and the Healthcare industry has witnessed growth at a rapid pace. People all over the world are becoming health conscious and strive for a healthy long life. One of the fastest-growing and promising sector in India is the healthcare industry, and is expected to grow in size to ₹ 2,00,000 crore by 2012 (Baxi, 2006).

India has become a hot medical destination for Middle-East, Africa, and even the developed west. Across the globe, the world is recognizing that Indian hospitals provide world-class healthcare facilities at more competitive rates. Even though the country seems to enjoy a good brand reputation in the health sector at the global level, but still, the situation is far from satisfactory. Notwithstanding the mushroom growth of hospitals in the urban areas, lack of good healthcare facilities in the rural areas is a serious concern for the nation. It is an undisputable fact that the total available healthcare centers are less in number than required. Interestingly, as against 2.4 million places of worship, India has the combined total of school and colleges (1.5 million) and hospitals (0.5 million); which comes out to be just 2 million (Bibek, 2006).

RESEARCH DESIGN

In the changed dynamic environment, it is difficult to determine the real feelings of a patient. Since the patient is the focal point in the hospitals, and his response depends on the satisfaction derived by his family members from the hospital administration and services, which gives confidence to the patient in facing the diseases (Mir, 2006). It is the responsibility of the administrator to keep the patient and his attendants in a satisfied state. The primary data was collected from patients by using a questionnaire, which consisted of 25 statements having five-point Likert scale viz. Not satisfied at all, Poor, Average, Good and Excellent was used to quantify the data. Mostly, the hospitals must strive for maximum patient satisfaction and provide patient oriented services. The total respondent strength selected for the research was 635 patients, where 315 patients were selected from Christian Medical College-Ludhiana (CMC-L) and 320 patients were selected from Sher-e-Kashmir Institute of Medical Sciences (SKIMS), Srinagar. The questionnaire was mostly used in the form of Schedule, however, in some cases, where the respondents were highly literate, they filled their questionnaires themselves.

Many of the variables have been used from time to time for the assessment and evaluation of quality of service provided to the patients (Carey & Seibert, 1993). However, the following dimensions were taken for evaluating SERVQUAL of healthcare and satisfaction level of patients towards the healthcare services in the present research study:

❁ **Dimensions :** *Reliability; Empathy; Responsiveness; Competence; Courtesy; Access; Communication; Security; and Physical Environment.*

REVIEW

The pursuit of quality healthcare has been the vital subject in the recent times, may it be government, non government or private bodies, which are concerned with the notion of *"health for all"*. Quality of healthcare services has a direct

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bearing on the nation's growth and prosperity. An assessment of quality of service provided by hospitals has been a serious concern these days for the hospitals and healthcare organizations, owing to the excessive demand imposed on them by various agencies, including consumers, government and society at large. However, efforts in this direction have not been quite successful to the desired extent. Due to lack of adequate infrastructure, professionalism and also because of its perishable, inseparable, heterogeneity and intangible nature in the health care services- poor-quality services are provided to the patients (Lovelock & Gummeson, 2004; Klassen, Russell & Chrisma, 1998; Kandampully, 1998; Mackay & Crompton, 1988; Svensson, 2003).

Many models were used from time to time to evaluate the design and delivery of service quality, and the most promising was "SERVQUAL" model devised by Parasuraman et al (1988) to improve the quality of services delivered to the patients and has been universally accepted. Parasuraman et al (1988) devised the "SERVQUAL" model, which consisted of five dimensions, which include tangibility, reliability, responsiveness, assurance and empathy. Gronroos (1984) has already elaborated on a two-dimensional model comprising of technical quality and functional quality, which was a primitive one. Lehtiness and Lehtiness (1991) set forth a two-dimensional approach to service quality consisting of process quality and outcome quality. They also introduced a three-dimensional approach comprising of physical quality, interactive quality and corporate quality. Rust and Oliver (1994) introduced a three-dimensional model of service quality encompassing the service product, service delivery and service environment. Brady and Cronin's (2001) three-dimensional model of service quality consisted of interactive quality, physical environment quality and outcome quality. The quality of Service delivery and customer satisfaction are inarguably the two core concepts that are the crux of marketing theory and practice (Spreng & Mackoy, 1996).

In the current highly dynamic environment, the key to sustainable competitive advantage lies in delivering high-quality service, that will in turn result in satisfied customers (Shemwell et al 1996; Yavas & Bilgin, 1998). In the service management framework, perceived value and customer satisfaction are distinct constructs that are highly interrelated (Ismail et al, 2009).Therefore, there is not even an iota of doubt concerning the importance of service quality as the ultimate goal of service providers throughout the world (Sureshchander et al, 2002).

Historically, in hospitals, there was a 'paternalistic approach' to decide what should be done for a patient; the physician knew best, and the patient accepted the recommendation without question. This era is ending, and is being replaced with consumerism, and shared decision making. Patient satisfaction with their care rests heavily on how successfully this transition is accomplished. Patients, the only reason for a hospital's existence, need services which are reasonably accessible and readily available at all times.

The ultimate goal of a hospital or healthcare organization is to offer to the patient, quality healthcare services so that their levels of expectations are fulfilled (Stephen & Sabina, 2003). There is direct evidence to link service quality and better company performance in terms of higher market share and improved profitability (Buzzell & Gale, 1987; Buzzel et al, 1975; Rust & Zahorik, 1993). The modern treatment based on advanced technology is not only costly, but is full of complexities. Hospitals are charging exorbitant amounts from patients in return for healthcare services, however, few of them offer world-class healthcare services. In today's hospitals, SAVE (Science, Administration, Value and Efficiency) is taking over from CARE (Compassion, Art, Reliability and Value). The hospitals are being recognized as social institutions apart from being curative ones, they are now considered as *'patient-focused focused centers'*. It has been observed through various studies that the quality of the public health care sector is quite low and inadequate. Patients are dissatisfied with the level of service provided in the public hospitals (Kara, et al, 2003).

DISCUSSION

Hospitals are trying to cope with the advances in health knowledge and technology, changing community needs and rising expectation of people for better healthcare. Today, patients and their families are more knowledgeable and have higher expectations of quality of care and services than ever before. This has been successful in increasing the level of expectations of patients. It is against this backdrop that the researcher found an apparent difference in between the quality of services offered by hospitals and the expectations from the patients.

❁ Perception Of Patients Towards Reliability Of Services Provided By The Hospitals : Reliability refers to assurance, credibility (Juwaheer & Ross, 2003) and normally, a patient has expectations related to reliability of core and allied services (physical context) from the healthcare organizations. The core service are related to direct interaction between doctor and patient (Chelladurai & Chang, 2000) and the augmented services include all the allied services of

paramedical staff given to the patients. It was revealed in the research survey that the satisfaction level of patients towards the promised services is somewhat higher in the CMC-L, which is depicted by the mean score 2.96±0.07 whereas, in the SKIMS hospital, it is low, i.e. 2.18±0.09. This can be attributed to the fact that the frequency of patients receiving services per doctor in SKIMS is somewhat higher than CMC-L.

❁ **Perception Of Patients Towards Empathy :** Empathy is related to caring, attention and understanding of individual customer needs (Chang, & Chelladurai, 2003), and his interests when dispensing the prospective core services (Juwaheer & Ross, 2003). The analysis reveals that majority of the respondents in CMC-L opined that both the medical and paramedical staff should give enough time for hearing out their concerns/queries regarding their illness, but unfortunately, because of huge patient rush in tertiary sector hospitals, it is very difficult on the part of medical and paramedical staff to give adequate time for hearing out the concerns/queries of the patients. However, it was observed during the survey that the staff was trying its best to reply to the queries posed by the patients and their relatives. Even a good number of respondents in CMC-L and also in SKIMS mentioned that the number of check-up rounds made by the medical and paramedical staff were quite reasonable. In CMC-L, the overall behavior of staff towards the patients was found good (mean score: 2.81±0.54) as compared to SKIMS, and hence, needs to be improved in the latter's case.

❁ **Perception of Patients Towards Responsiveness:** We want doctors who can empathize and understand our needs as a whole person. We put doctors on a pedestal right next to god. In these hospitals, the waiting time factor must be considered as an important objective for delivering the quick service. It was perceived that in CMC-L, the management has taken due care for reducing the waiting time, however, in case of SKIMS, it was not properly managed. It was found during the survey that poor patients have high expectations from the various actors of the hospitals, from which he expects to receive the services. The willingness of hospital staff to help patients and provide prompt service is the desire of every patient (Juwaheer & Ross, 2003) and normally, their expectation is more from the doctor than any other allied services of the hospital. The satisfaction level of patients towards this dimension in CMC-L is higher than it is in SKIMS, which is revealed from its mean score 2.88±0.09 and the Z_{cal} value.

❁ **Perception of Patients Towards Competence:** Competence about individuals is more or less a subjective term in the hospitals, and is spread through the word of mouth among patients. We want to feel that our doctors have incredible knowledge in their field, but every doctor needs to know how to apply their knowledge with wisdom. Mostly, the medical as well as paramedical staff of these hospitals complains about time management - that they have to work tirelessly for long hours, cope with patient rush, and also pursue their studies. However, it was found during the survey that satisfaction level of patients towards the competence and skill level of the medical and paramedical staff in CMC-L is higher, as evidenced by the mean score, i.e. 2.41±0.27 than it is in the SKIMS hospital (2.10±0.10) and mostly, respondents were found to be in the age group of above 40 years, and their qualification was found mostly below matric level. This can also be attributed to the fact that respondents with low levels of edification and age group beyond 40 years are more prone to sickness. This is further supported by the Z_{cal} value (Table 1) i.e. 2.06 at 0.05 level of significance.

❁ **Perception of Patients Towards Courtesy:** The link established in a doctor-patient relation is one of the important and essential elements for the creation of a quality practice, and every patient expects polite behaviour from medical and paramedical staff. The satisfaction level of patients towards the soft skills (courtesy) of the medical and paramedical staff is very high in CMC-L, as evidenced by the mean score 2.91±0.08, whereas, the patient satisfaction level at SKIMS was slightly low as compared to CMC-L, as revealed by the mean score of SKIMS 2.53±0.09; The general satisfaction level of patients towards the courtesy is a bit satisfactory, whereas, the population distribution of CMC - L and SKIMS hospital of the sample unit are showing greater degree of variation as depicted by the Z_{cal} value (Table 1).

❁ **Perception of Patients Towards The Accessibility:** Accessibility dimension in SERVQUAL is related to the general availability of core as well as allied paramedical services in and outside of the healthcare organization, and it is because of this accessibility in the region that a customer becomes a patient (Mir et al, 2007). The satisfaction level of the four hospitals towards accessibility dimension has somewhat little variation. In the mean score of CMC-L, the variation is 2.98±0.08; whereas, in case of SKIMS, it is 2.45±0.09; which may be due to the accessibility of many tertiary sector hospitals available in the sample area, whereas, the accessibility of services and tertiary sector hospitals is restricted to two only i.e. SKIMS and SMHS hospitals in the second sample region (Kashmir region).

Table: 1 : Comparative Perception Score of Patients in CMC-L and SKIMS												
S.No	Variable	CMC-L Hospital					SKIMS					
		Mean	S.D	S.E.	C.V.	Rank	Mean	S.D	S.E.	C.V.	Rank	Z_{cal}
1	Reliability	2.96	0.45	0.07	657.77	1	2.18	0.73	0.09	298.6	5	6.5
2	Empathy	2.81	0.54	0.09	527.37	6	2.22	0.75	0.09	296	6	4.4
3	Responsiveness	2.88	0.56	0.09	514.28	7	2.14	0.78	0.1	274.4	7	5.21
4	Competence	2.41	0.69	0.27	349.27	9	2.1	0.78	0.1	269.2	8	2.06
5	Courtesy	2.91	0.48	0.08	606.25	2	2.53	0.71	0.09	356.3	2	3.11
6	Access	2.98	0.51	0.09	584.31	4	2.45	0.73	0.09	335.6	4	4.2
7	Communication	2.84	0.53	0.08	535.84	5	2.44	0.7	0.09	348.6	3	3.17
8	Security	2.91	0.49	0.08	593.87	3	2.58	0.61	0.08	423	1	2.89
9	Physical Environment	2.72	0.57	0.09	477.19	8	2.11	0.95	0.28	222.1	9	3.91

❁**Perception of Patients Towards Communication:** Communication is an important component of patient care. Traditionally, communication in medical school curricula was incorporated informally as part of rounds and faculty feedback, but without a specific or intense focus on skills of communication per se. The reliability and consistency of this teaching method left gaps, which are currently getting increased attention from medical schools and accreditation organizations. In public health services, doctor-patient relationship tends to be impersonal, a link being formed with the service itself, but not between people (Denise et al, 2006). There is also increased interest in researching patient-doctor communication and recognizing the need to teach and measure this specific clinical skill. The satisfaction level of patients towards an interpersonal communication dimension between Medical staff and Patient, Paramedical staff and Patient and Medical and paramedical staff was at a satisfactory level in CMC- L, as evidenced by the 2.84±0.08 whereas, it was found that interpersonal communication in the hospitals of Kashmir region is poor in general and in particular, enormously poor among the medical and paramedical staff. It has long been recognized that difficulties in the effective delivery of health care arise from problems in communication between the patient and the service provider. Improvements in provider-patient communication can have beneficial effects on health economics.

❁**Perception of Patients Towards Security System:** Healthcare services are inherently personal, but not private. Normally, other services do not require customers to relinquish so much of their privacy or to bare themselves physically and emotionally as is required by medical services. To receive the best possible care, patients may not only have to disrobe, but they also have to discuss highly personal matters (Leonard & Neeli, 2007). The security and maintenance of privacy in all the hospitals is somewhat the same trend in all the hospitals. This is evident from the figures of CMC-L 2.91±0.08 and in case of SKIMS, it is 2.58±0.08. As far as the distribution of population is concerned, the population of CMC-L is different from the rest of the hospitals of Kashmir region, which is given by the Z_{cal} value as shown in Table 1, depicting the poor satisfaction level of patients in the hospitals of Kashmir. This can be attributed to the turmoil phase in Kashmir for last twenty years (CNN-IBN / The Hindu, 2006).

❁**Perception of Patients Towards The Physical Environment In The Hospitals:** The environment defines the complex mix of environmental features that shape consumer service perception (Gotlieb et al, 1994) wherein, atmosphere and tangibles are the key themes underlying customers' perception of environment quality. The first theme of the atmosphere refers to the intangible background characteristics of the service environment (Bitner, 1992; Dagger, et al, 2007). Tangibles comprise of the design, function, layout of the environment, the signs, symbols and artifacts found in the environment (Bitner, 1992). Many respondents at CMC-L opined that the number of beds needed to be increased considerably. However, respondents at CMC-L and SKIMS expressed their satisfaction towards cleanliness, but still, the satisfaction level towards this dimension was better at CMC-L than it was at SKIMS. As observed from the mean score of CMC-L, which was 2.72±0.09, whereas, in case of SKIMS, it was 2.11±0.95, and it was also proven by Z_{cal}, showing two different population distributions, giving a proof that the physical environment situation at CMC-L was better than what it was at SKIMS. Most of the patients suggested that the necessary medicines and surgical items required should be made available in the hospitals, even if they have to pay for it, and they should not be asked to run for these medical and surgical items (Waseem et al, 2005). It was also found that almost all the patients and their

attendants stressed that the hospital management should regularly visit the ward area to lend an ear to the grievances of the patients and should apply necessary remedial measures. In these circumstances, hospitals must strive for maximum patient satisfaction, as the patient satisfaction is a real testimony of the efficiency of a hospital.

CONCLUSION AND POLICY IMPLICATIONS

Healthcare is a rare service, which people need, but do not necessarily want. It is arguably the most personal and important service that consumers buy, yet many studies reported wide variations in the quality of the care delivered (McGlynn et al, 2003) and the ability to evaluate that quality (Adams & Michelle, 2002) hence, it was difficult to measure patient satisfaction (Candance et al, 2003). In hospital industry, if a patient is the raw material and patient satisfaction is the end product; manpower can be equated with the plant and machinery.

The organizations that have developed a reputation for consistently delivering high-quality services have done so by creating an excellent internal environment or culture for people (internal marketing), so that they are responsive to patients by providing exceptional customer service (External marketing) (Tarnow & Wiley,1991). Developing service-oriented culture in the hospitals requires more than single focus on the patient and can be perceived from medical, paramedical staff and customers' point of view (Denise et al, 2006). The high competition in the healthcare sector, both domestic and international markets, leads us to realize that all hospitals need to improve their service quality. To develop and to maintain the hospital image, the hospital staff must rely on the experience attributable to competence at work. Patients will generally form an impression of the staff as they experience various services during their hospital visit. It was also found during the survey that overcrowding and lack of adequate manpower (Andaleeb, 2001) is a serious concern in delivering the value to the patient. Hospital organizations should develop patient-focused care (PFC) for its long-term survival and, which can be achieved only by focusing on Continuous Quality Improvement (CQI) and coordination among the various departments in delivering the value care to achieve the desired outcomes. Consistently delivering high quality service requires hundreds of individuals performing numerous roles with a value added service orientation and also the multitasking approach to be adopted by the medical and paramedical staff (Mir & Elizabeth, 2008). The research also confirms that improving the quality of communication with patients by explaining medical procedures, discussing questions of concern and by consulting with them regarding their care can greatly enhance customer satisfaction (Mir et al, 2007). It has been found that patients were satisfied with professionals who gave customers' individual attention and understood their needs.

Hospitals should resort to periodical audit, which is a constructive method of assisting the management to improve operations of its business by pinpointing areas of cost reduction. However, hospitals can also resort to outsourcing of various functions, which are less technical in nature, to bring efficiency and effectiveness in the operations, which can therefore, increase the employment opportunities in the adjacent areas (Mattoo & Mir, 2006).

The concept of *'Evening Clinics'* to target the working and affordable population with differentiated *'boutique services'* would not only enhance financial conditions of the hospitals, but also organizations can pay more to their employees by involving them in evening clinics, which can check the brain-drain problem in India (Mir, 2003; Mattoo & Mir, 2005). Furthermore, by adopting the *'compassionate capitalism'* philosophy, where best customized services are provided to the upper income group at a premium price and thereby, the surplus revenue generated from the upper class is used to finance the service quality delivered to the poor and middle-income group at penetration pricing, thus serving all economic groups of the society (Mir, 2006). Moreover, hospital management should reward those units with higher patient satisfaction so that the units with fewer satisfied patients have some incentives to work better for higher satisfaction.

It is the need of the hour that the government introduces some National Quality Accreditation Surveys in order to bring the competition among the public-private hospitals in both rural and urban areas (Mir et al, 2007). This will bring about some pressure on hospitals to improve the supply-chain management (SCM) in the healthcare services and ultimately force them to adopt Total Quality Management (TQM) techniques in their operations. This could indeed be a formidable foreign exchange earner and for the successful implementation of the long cherished universal goal of the *'Health for All'*.

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