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Literature Reviews Relating to Service Quality of Health Care Systems

Nisha Joseph

Assistant Professor of Commerce, Al – Ameen College, Edathala, Aluva, Kerala.

Abstract:

All sectors in India are undergoing a change from unorganised to an organised structure and so is also seen in healthcare.Notwithstanding the sector's rapid growth and potential, in many respects, India's healthcare falls well below international benchmarks for physical infrastructure and manpower and even falls below the standards existing in comparable developing countries. Thus, India's healthcare sector needs to scale up considerably in terms of the availability and quality of its physical infrastructure as well as human resources so as to meet the growing demand and to compare favourably with international standards. Also, despite the giant steps taken by the Indian healthcare industry, there is a need for improvement in customer service.A comprehensive review of literature has been carried in the present work that discusses the quality of healthcare related to Indian studies and assesses the definition of service quality and development of SERVQUAL.

Keywords: Health, Health care system, Service Quality,SERVQUAL.

INTRODUCTION

A health system, also sometimes referred to as health care system or as healthcare system, is the organization of people, institutions, and resources that deliver health care services to meet the health needs of target populations.Service quality in health care is very complex as compared to other services because this sector highly involves risk.A comprehensive review of literature has been carried in the present work that discusses the quality of healthcare related to Indian studies and assesses the definition of service quality and development of SERVQUAL.

Health is clearly not the mere absence of disease. Good health confers on a person or groups' freedom from illness and the ability to realise one's potential. Health is therefore best understood as the indispensable basis for defining a person's sense of well being. The health of population is a distinct key issue in public policy discourse in every mature society often determining the deployment of huge society. They include its cultural understanding of ill health and well-being, extent of socio-economic disparities, reach of health services, quality and costs of care and current bio-medical understanding about health and illness. One widely accepted health

definition is in the World Health Organization's (WHO's) constitution: "Health is a state of complete physical, mental and social well being and not merely an absence of disease or infirmity" [WHO, (1948), p.100]. In recent years, this statement has been amplified to include leading a socially and economically productive life [Park, (2007), p.13].

All sectors in India are undergoing a change from unorganised to an organised structure and so is also seen in healthcare. The growth and sudden interest in the healthcare business can be attributed to many factors. Some of them are: strong Indian economy, increasing options for healthcare financing, growth in medical tourism, increasing opportunities in healthcare delivery, saturation of other sectors like IT, retail and gradual corporatisation of the healthcare sector.

Notwithstanding the sector's rapid growth and potential, in many respects, India's healthcare falls well below international benchmarks for physical infrastructure and manpower and even falls below the standards existing in comparable developing countries. Thus, India's healthcare sector needs to scale up considerably in terms of the availability and quality of its physical infrastructure as well as human resources so as to meet the growing demand and to compare favourably with international standards. Also, despite the giant steps taken by the Indian healthcare industry, there is a need for improvement in customer service.

OBJECTIVE OF THE STUDY

- To review the literatures on healthcare quality related to Indian studies
- To review the literatures on service quality and its development of SERVQUAL as tool for measurement

LITERATURE REVIEWS ON HEALTHCARE QUALITY RELATED TO INDIAN STUDIES

Deshwal et al. (2014) attempted to categorize the SQ dimensions that play an important role in patient satisfaction in campus clinics in Delhi and found out that the dimensions that affects patient satisfaction were: staff professionalism; clinic staff reliability; clinic accessibility and basic facilities; tangibles; cleanliness; awareness of the clinic/diseases and how clinic staff deals with emergencies

Padma et al. (2014) resorted to provide strategic recommendations to Indian hospital administrators for improving SQ by analysing performance dimensions and reached a conclusion that different customers have different needs of which providers need to be aware to better serve their consumers

Chaudhuri and Lillrank (2013) was able to identify capabilities required for healthcare service providers to provide mass services and provide directions to conduct empirical studies to understand the phenomenon of mass personalisation

Talib and Rahman (2013)examined the current status and demographic characteristics of Indian healthcare and hospitality industries and presented a holistic picture of current status of these two Indian service industries which may help the Indian service managers and practitioners to further exploit opportunities in these two industries

Azam et al. (2012)conceptualised quality parameters in healthcare establishment (HCE) at professional technical level as well as at supportive managerial level and validated the parameters with acceptance of these quality dimensions by the hospital staff appreciating its practical utility for patient care both from professional technical and management point of view

Khan et al. (2012)measured Service Quality performance in corporate hospitals and established that the ranking of the dimensions like reliability, assurance, tangible, empathy and responsiveness were done to get best quality of services

Narang (2011) measured the perception of patients towards quality of services in public healthcare centres in rural India and found that variables like education, gender and income were found to be significantly associated with user perception.

Chahal and Kumari (2011) tried to examine the three dynamics of customer relationship management (CRM), namely, Service Quality, Customer Satisfaction and customer loyalty in the healthcare sector through indoor patients' judgment and confirmed the direct effect of CRM dynamics

Yeoh (2011) contributed to the literature on emerging multinationals by studying the internationalisation strategies of two established companies in the Indian pharmaceutical industry: Ranbaxy and Wockhardt and suggested that the mainstream internationalisation models are more effective in explaining exploitative learning while the emerging internationalisation models are more effective in explaining exploratory learning

Gaur et al. (2011) examined how patients' loyalty and confidence in their doctors, are influenced by doctors' interaction behaviour, namely, listening and explaining behaviour and demonstrated that doctors' interaction behaviour is instrumental in developing an effective relationship with their patients and boosts patients' confidence in their doctors and that effective interaction enhances patients' loyalty to their service providers.

Dongre et al. (2010) evaluated the possibility of marketing specific low-cost drugs across segmented markets in India and revealed that patients would be happy and would have better access to medicine if the same is offered at a lower price.

SERVICE QUALITY

Service quality (SQ) is a comparison of perceived expectations (E) of a service with perceived performance (P), giving rise to the equation SQ=P-E.[1] This conceptualistion of service quality

has its origins in the expectancy-disconfirmation paradigm. Service quality can be related to service potential (for example, worker's qualifications); service process (for example, the quickness of service) and service result (customer satisfaction)

Existing literature studies on Service have indicated that the service quality and customer satisfaction are indeed independent but are closely related that and a rise in one is likely to result in an increase in another construct. This section presents an overview of the existing literature on the definitions of SQ, the development of Service quality tool for its measurement

DEFINITION OF SERVICE QUALITY

According to Padma et al. (2009), SQ means perceived SQ, the literature on healthcare SQ has considered evaluating services from patients' perception. Patients are interested not only in the quality of care but also in the quality of service. Generally, healthcare organisations do not pay significant attention to quality of services.

Lim and Tang (2000) argued that SQ can be used as a strategic differentiation weapon for building distinctive advantages.

The literature on SQ suggest that it can be broken down into two distinct dimensions (Grönroos, 2000; Zineldin et al., 2011). They are: technical dimension and process/functional dimension. Technical dimension in the healthcare sector is defined primarily on the basis of the technical accuracy of the medical diagnoses and procedures, or the conformance to professional specification and standards. Functional dimension refers to the manner in which the healthcare service is delivered to the patients and quality of patient relationship with the organisation.

Parasuraman et al. (1988), who developed the widely used SERVQUAL scale, defined SQ as a judgment or evaluation relating to service superiority. They explained SQ on five dimensions i.e., tangibility, empathy, assurance, reliability and responsiveness. They further elaborated SQ as the gap between customers' expectations of service and their perception of the service experience. They proposed SERVQUAL framework to assess perceived SQ for variety of sectors.

According to Rust and Oliver (1994), SQ stems from service Service quality in healthcare establishments: a literature review 11 specific attributes or cues, while satisfaction involves a wider range of determinants, including quality judgments, needs and equity perceptions. They developed a three dimensional concept of SQ: service product, service environment and service delivery.

While Otani et al. (2009) observed that the excellent service attributes that influence on patient satisfaction and loyalty are admission, nursing care, physician care, staff care, food and room.

Similarly, Camgöz-Akdağ and Zineldin (2010) asserted that SQ in healthcare not only depends on the quality of physicians but also includes the staff, nurses, building, waiting room, equipments and machines used during care of patient. It can further be said that healthcare quality and patient satisfaction is more detailed than just dividing the quality of service into technical and functional dimensions. The technical, functional and SERVQUAL quality models can be expanded into a structure of five quality dimensions namely quality of object-the technical quality, quality of processes-the functional quality, quality of infrastructure-the basic resources, quality of interaction-measures the quality of information exchange and quality of atmosphere-the relationship and interaction process between the parties are influenced by the quality of the atmosphere in a specific environment where they cooperate and operate (Zineldin, 2000).

DEVELOPMENT OF SERVQUAL

Parasuraman et al. (1985) asserted that perceived SQ is an overall evaluation similar to attitude. They proposed that SQ is a function of the differences or gaps between customers' expectation and performance along the quality dimensions and therefore, this model is called 'gaps model'. Gaps model indicates five gaps during service delivery process, which may lead to dissatisfaction of the customers. Later, Parasuraman et al. (1988) refined their existing model and came up with a new scale to measure SQ known as 'SERVQUAL'. This scale consisted of five dimensions namely tangibles, reliability, responsiveness, assurance and empathy.

The description of these dimensions is as follows:

• tangibles-physical evidence in a service facility (e.g., personnel, equipment, etc)

• reliability-ability to provide services accurately and dependably

• responsiveness-readiness or quickness in responding to customers' needs

• assurance-courtesy and knowledge of the employees and their ability to convey trust and confidence

• empathy-caring and individualised attention provided to customers.

Since than several SQ models have been evolved from different authors' works (Table 2). But Parasuraman et al. (1985, 1988) SERVQUAL model is the prominent one. Despite controversies regarding SERVQUAL validity and reliability (Purcărea et al., 2013; Newman et al., 2001; Cronin and Taylor, 1992); its application, with or without modification, is common especially in healthcare sector. Parasuraman et al. (1991) further addressed the issues raised by Babakus and Boller (1992) by vindicating the use of gap scores for measuring SQ. They modified the negatively worded items in their instrument to improve the overall reliability values of the scale. Cronin and Taylor (1992) disagreed with the gaps-score measurement and proposed that

measuring SQ in terms of performance alone would be sufficient and developed performance-only measurement scale, which is known as 'SERVPERF' instrument. Parasuraman et al. (1994) responded to these concerns and again revised their original instrument accordingly. However, Carman (1990) arrived at a different dimensional structure while using SERVQUAL scale in a study pertaining to hospitals. Nine dimensions were found: admission service, tangible accommodations, tangible food, tangible privacy, nursing care, explanation of treatment, access and courtesy afforded visitors, discharge planning and patient accounting. These dimensions explained sufficient variance in SQ.

CONCLUSION

SERVQUAL quality is a multidimensional concept and in order to operationalise it, many variables have to be considered.

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