

Chapter VI

DISCUSSION AND SWOT ANALYSIS



INTRODUCTION

This chapter presents the interpretations of the findings that have been presented in Chapter V - Parts I and II. The format of taking up each of the study objectives in ascending order for discussion has been followed for organizing the content in a consistent style. The plausible reasons for the findings have been presented with evidence from other researches wherever applicable. In cases where this study has found a new link or finding, it has been mentioned that it is specific to this case or that such an attempt has not been made earlier in other studies.

6.1: *OBJECTIVE 1: Factors or Domains of Inpatient Service Quality: Functional / Technical Quality:*

The findings of this study indicate that "functional" or interpersonal or soft factors are considered more important than "technical" or clinical or hard factors of service quality. This is in conformance with earlier studies (¹Cartwright and Anderson 1981, ²Steiber 1988, ³King 1985 cited in Omachonu 1990, ⁴Bopp 1990, ⁵Bertakis et al 1991, ⁶Babacus & Mangold 1992, ⁷Elbeck 1992, ⁸Sharma 1993, ⁹Tomes & Chee Peng Ng 1995, ¹⁰Weatherall 1995). Although during the initial discussions for preparation of the research instrument, all the patients gave foremost importance to clinical outcome or getting cured / relieved, this did not emerge as a factor during the administration of the questionnaire. This finding can be explained by the fact that although clinical outcomes may form part of the "hygiene" factors (Babacus, 1993)¹¹ and are the reason for the patients seeking the services of this hospital, they are not able to judge such technical quality attributes. Indirectly, the high expectation scores for questions related to the image and credibility of the hospital have shown the predominance of this factor. (¹²Nelson & Goldstein 1989, ¹³Lehtinen & Laitamaki 1985, ¹⁴Elliot, Hall & Stiles 1992). Affective rather than cognitive judgement is more likely to dominate the evaluation of the service delivery



process if the number of experience and credence qualities increase relative to the number of search qualities, which is typically the case for healthcare services. However, to a large extent these more affective value judgements remain based on concrete attributes and experiences with the service delivery process. (Lutz cited in Vandamme and Leunis, 1993)¹⁵

Reliability and Validity:

The Cronbach's alpha scores indicate a high Internal Consistency Reliability for each of the sub-scales. The overall scale reliability was 0.7145, which shows that the items are internally consistent and measure the underlying hospital quality construct with a high level of reliability.

Content Validity or Face Validity of the scale has been established by subjecting the scale items to evaluation by a sample of doctors and patients.

The six-factor scale for measuring hospital service quality is able to explain 63.6% of the total variance, which is regarded as acceptable in social science research.

Image / Credibility:

The factor loadings are the highest for this factor as a consequence of the high expectation scores given by the respondents. Many researchers have argued that owing to the complex nature of healthcare as a service, most patients are not capable of evaluating the technical quality; they infer this through the image quality and functional quality (¹⁶Elliot, Hall & Stiles 1992, ¹⁷Lutz cited in Vandamme and Leunis, 1993). This study also brings out a similar finding.

Empathy:

The respondents have considered interpersonal qualities like empathy, respect and communication very important. Reading the findings for expectations of empathy in combination with the qualitative findings, patients expect to be treated as persons with emotional needs, and not



'processed' in a mechanical way. (also reported by Tomes & Chee Peng Ng 1995)¹⁸ They would like the caregivers to speak to them in their mother tongue rather than in English.

Respect:

The respondents have their own uniquely defined needs for respect. (Tomes & Chee Peng Ng 1995)¹⁹ This domain included questions on courtesy and privacy. Although all patients expected caregivers and support staff to be courteous, they did not give as much importance to the existence of a complaint mechanism, or to their permission being sought before students examined them. There was a positive attitude and a sense of pride in their being of help to students in their learning process.

On privacy the only aspect of concern to the respondents (especially of the obstetrics and gynaecology wards) was in the choice of a female doctor. They had to make a lot of psychological adjustment to get used to male doctors treating them and students being present during some of the examination procedures. This aspect cannot be catered to by this hospital, as choice of physician is an extremely difficult assurance to make in this setting. The respondents did not prefer seclusion or drawing of screens around the bed during examination, if done in the ward, as they associated this with serious deterioration or near fatal health conditions. They had witnessed many patients' death after such a phase. Noise was welcome in the ward and was a source of comfort and security indicating the presence of other people in the ward. Some patients in the special wards preferred to come out and socialize with other patients rather than remain alone in their wards. They resented being confined to their wards even if advised seclusion due to medical reasons like taking total bed-rest, or avoiding infection. Elbeck (1992) also brought out the need for socialization with other patients and hospital staff.²⁰



Communication:

The respondents expected to be given all information regarding discharge advice, results of tests and procedures, and instructions and information about medication. They did not expect very elaborate explanations about the diagnosis and treatment options and preferred leaving this aspect to the caregivers. Fitting this expectation into the information sharing models proposed by Charles, Gafni and Whelan (1997) ²¹, patients here use a combination of the paternalistic and the professional agent model; they want information to be given but the treatment decisions to be made by the doctor.

Responsiveness:

Patients expected to be helped to find the way around within the hospital, assistance in moving around to get tests or procedures done in various departments of the hospital, and quicker response from nursing personnel to their calls for assistance. They were also of the view that a more responsive atmosphere could result if some services were priced. They correlated low responsiveness with provision of free services.

Cleanliness:

A reasonable level of cleanliness was expected from the hospital. Questionnaire items like pleasant appearance of the hospital, wards and waiting areas, that could have shown some relationship with this factor, did not emerge in the responses. The patients probably clearly expected only cleanliness and were not particular about the hospitality elements that characterize hospitals in the corporate sector.

6.2: OBJECTIVE 2: Patients' Expectations / Perceptions of Hospital Service performance:

The hospital satisfies and even exceeds patients' expectations on the domains of respect, cleanliness and credibility. This finding can be linked to the teaching and research affiliation of the institution. As students have



to be taught the correct clinical practice guidelines, the consultants insist on strictly maintaining a relationship of respect and seeking patients' permission before performing any examination or clinical procedures. The cleanliness of the wards in this hospital has been rated high given the expectations from a public sector hospital.

Patients' rating the hospital's performance on the domains empathy, communication and responsiveness much below their expectations could be due to the fact that consultants' time spent with patients is not exclusively devoted to patient care. Teaching of clinical skills is concurrently done and the attention of the caregivers is divided between the patients and students. The number of patients being seen by a doctor could be another contributing factor. Fleming (1981) reported that despite the perceived technological superiority of teaching hospitals, patients express greater dissatisfaction due to the emphasis on the dual priorities of educating medical personnel and providing high quality care. The doctors' patterns of behaviour may offend some patients and be translated by them into poor quality care.²² A commonly expressed comment from patients during this study was "everyday groups of doctors stand at our bedside and discuss for a long time in English. But we are not told the details in a way that we can understand." This finding is an indicator to the hospital that interpersonal quality or the bedside manners of the caregiver is far more important than just doing what is medically essential for the patient.

6.3: OBJECTIVE 3: Factors related to Service Quality Gaps

PATIENT RELATED FACTORS:

a) Demographic characteristics:

Service quality expectations and performance perceptions do not seem to be related to the **gender** and **geographical location** (urban or rural) of patients. Female patients perceive a lesser gap between expectations and



performance indicating greater satisfaction levels. Patients' gender does not appear to have any consistent relation with satisfaction.

Four studies showed women to be more satisfied, eight showed no difference and five showed men to be more satisfied (Hall and Dornan cited in Rees Lewis, 1994).²³

Higher **education** level leading to higher expectations has been reported by other researchers as well, but they included respondents with college degrees. While other studies reported that lower satisfaction levels were associated with high education, this study showed higher performance perceptions with higher education level. Another finding that emerged from this study was that the respondents with no education at all had better satisfaction levels than the group with 1 - 9 years of education. It must be noted that the nodal value in the high education group was 13 years of education i.e., high-school education. Patients with college degrees were very few. Taking these findings in totality, it is obvious that formal school education as a stand-alone variable is of little value. There must be some other underlying factor that can better explain the relationship with satisfaction. Although awareness of health related issues could increase with formal education, this study's findings of the nil education group show that such a link is not a necessary condition. Health education could be given independent of formal schooling. This finding could be useful for designing programs to encourage patients to play a more active role in their care.

Income as a demographic factor has not been considered in this study as the data provided by patients was not found to be reliable. In order to use the services free of charge, many patients reported an income below Rs.1000/- although on indirect cross verification, this did not seem to be factually correct.



b) *Psychographic Characteristics:*

The more the ***perceived severity of illness***, the lower was the overall service performance perception and specifically due to low ratings for the communication regarding tests and procedures. Although many investigations were done, the patients felt that they were not told about the results. In the responsiveness domain, the patients who perceived themselves to be severely ill had higher expectations. Similar results were reported from other studies (²⁴Calnan 1988, ²⁵Zapka et al 1995).

Patient Involvement in their own care in terms of seeking knowledge about their illness, self-care, cleanliness, and helping other patients and hospital staff had a significant effect on hospital performance perceptions. A cross-tabulation of education levels with level of involvement of patients showed mixed results: Out of 26 patients with nil education, 13 (50%) showed high involvement. Twenty (49%) out of 41 patients with low education level showed high involvement. Thirty (83%) out of 36 patients with high education level showed high involvement. This finding indicates that although education seems to significantly enhance involvement (Chi-Square value = 11.460, df 2), the relationship is not simple. The respondents in the nil and low education groups are equally divided between the high and low involvement groups.

Education is providing only the cognitive input to involvement and is obviously not adequate to explain the attitudinal and behavioural characteristics shown by high or low involvement groups. High Involvement seems to make patients take initiative and responsibility and participate actively in the service process. Low involvement on the other hand, results in increased dependence on the service providers and a passive attitude to the care process.

Although involvement is partly an internally controlled trait, it could be possible to induce or enhance the level of involvement at least at the



behavioral level by rewarding actions or behaviours that contribute to patients' own care. Encouraging patients to be more involved will not only quicken the recovery, but will also reduce the burden of doctors and nurses to a large extent.

In services marketing, enhancing consumer participation in the service delivery process is done by means of "interactive marketing" (Kotler). This can consist of educating consumers to understand and use the service more responsibly, participate in self-service elements in the process, and comply with expected post-service behaviours. Taken further, involvement can help in promoting the image of the service provider.

Health care providers have to put in some extra effort on effective customer management as it can produce significant value to the organization in terms of reduced staffing requirements, lower costs, quicker recovery time, shorter length of hospital stay, and thus, better financial results (MacStravic, 1988) ²⁶ There is more than cost at stake. The quality of care itself can be improved by enlisting the patient as an active partner in care, not merely as a passive recipient of a service. There are benefits to the care process by an informed, participatory patient. (Levin, 1995) ²⁷ The role of a "patient circle" in generating a workable methodology for incorporating consumer perceptions, problem solving and image building is important. Tomes and Chee Peng Ng (1995) ²⁸

c) ***Service Purchasing Behaviour:***

Whether the patients had previously sought treatment from private or government run hospitals for the same health problem, it made little difference to their expectations or hospital performance perceptions. There are no earlier studies on this aspect. ***History of previous hospitalization*** not making any statistically significant difference to patients' expectations or performance perceptions can lead to two possible conclusions. Either



the theory of experience-based norms being applied to service situations has to be questioned, or both private and public hospitals probably behave in a similar way when it comes to catering to patients' salient expectations in terms of the six domains identified by this study. By any learning theory, previous experience has to necessarily influence future beliefs and behaviours. Hence, from these findings, it makes better sense to discard the first conclusion and accept the second conclusion as valid. Studies that directly compare private and public hospital services are not tenable, as the two settings are dramatically different from each other in terms of many of the facilities and patient : care-givers ratios. Therefore this finding, although indirect, deserves merit and brings into question the quality of service rendered by private providers being perceived equal to that of this public hospital despite the prices being charged by the former. Are patients paying private hospitals for the same quality of services? Can this hospital charge a price for services and thereby improve its facilities? A study that could bring out the position of this hospital in the consumers' mind vis-à-vis private hospitals (corporate hospitals, smaller nursing homes, etc.) and non-teaching government hospitals could be useful and provide a clearer picture.

Patients' expectations and hospital performance perceptions differed significantly depending on their **payment status**. Paying patients having higher expectations is understandable. They also rated the hospital higher on performance as compared to non-paying patients. Twenty-two (78.5%) of the 28 paying patients showed high level of involvement in their own care. Thirty-four (45%) out of 75 non-paying patients showed high involvement. Payment status is significantly inducing involvement (Chi-Square value = 4.905, df 1). This direct relationship between payment status and involvement has to be further explored and established to see whether patient involvement and satisfaction can be enhanced if they pay



for the hospital's services. Paying patients will probably feel more equal in the provider-patient dyadic relationship and have greater bargaining power in demanding and getting quality service.

d) ***Provider Behaviour:***

Hospital performance ratings are significantly higher if the patient knows an employee. ***Knowing a hospital employee*** makes it easier to get information from doctors and nurses and better responsiveness from support staff especially in a setting like a teaching government hospital where most of the services face a high demand that has to be met against constraints of resources and time. This factor is specific to a public hospital situation and has not been studied earlier.

e) ***Process Factors:***

The significantly lower expectations of patients who get ***all facilities free*** as compared to those who pay for some or all of the facilities is understandable and has already been discussed with reference to the payment status of patients. This factor is also specific to a public hospital situation and has not been studied earlier. There has to be some attempt to study this factor thoroughly so that better pricing decisions as well as matching quality improvement measures can be implemented. Cross-subsidization can be more effective both for the hospital and the patients if greater attention is paid to such a customer focus.

f) ***Clinical Outcomes:***

Patients with positive clinical outcomes like "cured" or "relieved" gave significantly higher ratings to the hospital's service performance on all the domains of quality. As this study design involved getting immediate feedback from patients at the time of discharge from the hospital, the gratitude factor could have led to these ratings. Further study of patients' perceptions during the post-discharge follow-up phase could be useful in arriving at conclusive data. Other studies designed to study patients'



perceptions at varied periods after discharge have shown inconsistent results. A cross-tabulation of clinical outcomes with patient involvement showed that while 96.8% (n = 63) of the high involvement group showed improved outcomes, only 62.5% (n = 40) of the low involvement group showed positive or improved outcomes (Chi-Square value = 20.918, df 1). Patient involvement seems to have a direct and positive influence on clinical outcome. It would be useful to verify this association between involvement and outcomes and to study the effect of interventions that can enhance patient involvement.

6.4: OBJECTIVE 4: Providers' Insight into Patients' Perceptions:

Doctors seem to think that their patients' expectations from the hospital are significantly higher than patients actually do. Performance perceptions of the two groups are not statistically significantly different. This indicates that doctors perceive a larger gap between what they think are patients' expectations and performance perceptions. Compared with the high expectation levels, doctors think that they have delivered poorer quality to their patients. This over-rating of expectations could result in the mindset that patients' expectations are not in the realm of what is practically achievable and therefore are impossible and ideal targets to work on. While some studies report that physicians are more critical of themselves (Rashid et al 1989)²⁹, others report that providers feel that they have done more (³⁰Martin et al 1991, ³¹Kaul and Kaul 1999). Patient feedback has to be obtained on a regular basis to understand and bridge the gap between expected and perceived quality levels as perceived by the providers and the consumers of the service (³²Like and Zyzanski 1987, ³³Rashid et al 1989, and ³⁴Brown and Swartz 1989).



ANALYSIS OF SPECIAL WARD PATIENTS' SAMPLE:

Section 5.6 (ii) of the Findings Part I of this study focuses on the special ward admission data. This analysis was incidental consequent to the problem faced in getting a satisfactory sample of special ward patients for the main study.

There is an immediate necessity for increasing the availability of special wards so that there is more equity in access and patients are not turned away from the hospital for want of a ward of their choice.

Patients admitted under the Obstetrics Fertility Clinic and Orthopaedic Surgery are seen to be monopolizing the special ward services, the former in terms of number of patients and length of hospital stay and the latter in terms of length of hospital stay. It must be noted that orthopaedics patients' special ward occupancy is in addition to a separate building with 58 beds that is available with general ward facilities. This preliminary analysis indicates a strongly felt need for a separate Maternity Centre and a Trauma Care Centre. The Maternity Centre could cater to the high demand for assisted childbirth or fertility clinics by earmarking a proportionate portion of the facilities. The Trauma Care Centre could cater to the increasing influx of road traffic and other accident victims.

Analysis on these lines is possible only if the records are computerized and updated. The wealth of data that is potentially available if the computerized records are up-to-date is of tremendous use to the hospital administration. Programs to break the psychological barriers to using the existing computers and to motivate personnel to maintain and use the data should be initiated.



6.5: OBJECTIVE 5: *Determinants of Inpatient Service Quality*

The multiple regression model includes four of the independent variables as predictors of service quality of this hospital. The strong association between performance perceptions and patient involvement, hospital employee known, and clinical outcome has already been shown earlier. Length of hospital stay has been seen as another independent variable that predicts service quality.

The regression or beta coefficients' being positive suggests that the greater the involvement score and length of hospital stay, the greater is the perceived quality score. Likewise, the perceived quality score is higher if the patient knows a hospital employee and the clinical outcome is positive or 'improved'.

Patient involvement and clinical outcome are related to each other as already shown. On the one hand, greater length of hospital stay could lead to inpatients becoming familiar with the working of the hospital and establishing rapport with the employees and therefore likely to get them to be more responsive to their needs. On the other hand, patients could become more self-reliant as hospital "veterans" as expressed by one of the senior consultants. Although the predictor variables are correlated, they are not collinear as has been tested and shown using Tolerance measures and the Variance Inflation Factor (VIF). The Adjusted R Squared shows a 60.4% predictive value of the model.

6.6a: OBJECTIVE 6a: *Perceptions of Main Contact Employees - Doctors:*

The dipstick survey of doctors regarding the current and targeted organizational culture of the hospital showed a predominance of the Functional Hierarchical orientation emphasizing order, authority, security and entitlement. Similar findings were reported in public sector hospitals by



other researchers (³⁵Vestal, Fralicx & Spreier 1997 US, ³⁶Harber, Ashkanasy & Callen 1997 Australia, ³⁷Dutta Roy & Ghose 1997 India).

Adherence to the status quo, although considered necessary and unavoidable in many government organizations, has to make way for other more dynamic cultural orientations in response to environmental needs. Quality programs depend on autonomy (³⁸Murray & Frenk 2000), flexibility, customer focus (³⁹Albert 1989), quick response times, and sharing resources through networking arrangements (⁴⁰Zuckerman & Kaluzny 1991, ⁴¹Kanter 1994, ⁴²Halverson et al 1997, ⁴³Kizer 1997).

Internal marketing or providing for a greater employee focus is also needed to motivate employees to give better services (⁴⁴MacStravic 1988, ⁴⁵Albert 1989, ⁴⁶Elliot, Hall & Stiles 1992, ⁴⁷Harber, Burgess & Barclay 1993, ⁴⁸Anderson 1994, ⁴⁹Burns & Beach 1994, ⁵⁰Halder 1994, ⁵¹Lewisohn & Reynoso 1995).

As the gap scores indicate, the hospital is farthest from its target status in the networking, time-based reactivity and employee / customer focus process domains. The doctors felt that there was no recognition for superior performance or deterrent to inferior performance, very little autonomy to the institution as a whole, a consequent slowing down of decision making and resource constraints impeding creativity. This survey was exploratory and conducted on a very small group of employees at a particular level in the hierarchy. An organizational culture assessment across all types and levels of employees could generate useful information and draw focus to areas requiring intervention.

6.6b: OBJECTIVE 6b: Perceptions of Main Contact Employees - Nurses:

Nursing Tasks: Patient Care versus Record Keeping: All the nurses perceived that the extent of time they were able to spend on patient care was inadequate and the time spent on record keeping was



disproportionately higher. This study used a self-reporting technique rather than work-study and did not include idle time. The ratio of percentage time spent on patient related tasks to ward and record keeping tasks works out to 50 :50 overall.

A work study of nurses in a medical ward of a super speciality hospital in India reported a ratio of 43 : 30 (27% non-productive) (Sarma et al, 1998)⁵² A ratio of 21 : 59 (19% idle time) was reported before an intervention with a Patient Focussed Care (PFC) Model and an improved ratio of 40 : 47 (13% idle time) after the intervention (Moffitt et al, 1993)⁵³

The possibility of cutting down the time spent on record keeping can be assessed after a work-study that may confirm or disprove the perceptions of the nurses. In any case, if the volume of record keeping work cannot be brought down in the current circumstances, the nurses must either be educated about the importance of the records and / or motivated to regularly use the computer facilities that are available in the nursing station attached to each ward. The hospital's computerization program does not seem to have been communicated and marketed effectively to the participants and entering data into the computer is seen as cumbersome and an additional burden by the nurses. They continue to manually enter all data into multiple registers maintained in the wards.

Ward Maintenance - Cleanliness: Maintaining cleanliness in the wards was seen as a problem area by nursing personnel, as they had no control over sanitary support staff. Nursing and sanitation come under different hierarchies in the hospital although their functioning is highly interdependent. Such working relationships are potentially ideal conditions for internal marketing programs wherein employees are made to realize that they are 'customers' to each other within the overall service process. The effect of motivational interventions like "Best Wards" schemes decided using surprise checks could be studied. The practice commonly referred to



in marketing as the Mystery Shopper format may be applied and any of the hospital employees from higher levels may be designated as the jury. While nurses could derive intrinsic satisfaction from their jobs when they see patients improving under their care, sanitation personnel have little to aspire for, as their work is not intrinsically and obviously rewarding in a public hospital where aesthetics and hotel elements generally find a lesser place. Therefore sanitary staff have to be extrinsically motivated and recognized by designing minor internal mechanisms for assessing and rewarding their work. As any change in reporting relationships is not practicable, schemes that enhance the sense of pride in work may be the most viable alternative.

Ward Maintenance - Rules: Difficulty in enforcing discipline in the wards both from patients and visitors was another problem faced by nurses. During the study, it was observed that crowds of visitors including very young children were coming to see the patients disregarding the risks of infection that they could contact from or bring into the hospital. The hospital has to first strictly limit the number of visitors per visit and also deter crowds of visitors by levying visitor charges as is practiced by private and corporate hospitals. Patients should be educated about the risks to their own health if they break the hospital rules.

Nursing Role Efficacy:

The Nursing Role Efficacy scores reveal that the role perceptions are near the midpoints of the sub-scales, and tending towards the positive direction. Purohit and Pareek in their own study found the scores to be much lower. The positive role perceptions can be effectively channeled to enhance their quality of work life as well as the quality of patient care. The perception of a distancing in their working relationships with the doctors and the increasing feeling that they did not belong to the same care-giving team, has to be addressed through communication and team building workshops



including doctors and nurses. "Doctors in healthcare organizations have maintained a parochial dominance in a team context firmly based on their medical knowledge and expertise." (Klinge et al, 1995 cited in Harber et al, 1997) ⁵⁴

The nurses' perception of role shrinking due to lack of up-to-date knowledge has to be addressed through training and continuing medical education (CME) programs. "Limited opportunities for meaningful work lead to feelings of inferior ability and lower prestige." (Davis and Churns, 1975 cited in Harber et al, 1997) ⁵⁵

Senior nurses could design attitude-building workshops using experience-sharing methods in order to enhance the sense of pride in the profession. The sense of belonging that they feel could be conveyed and shared with the newly recruited nurses. Such exercises in communicating professional experiences could also re-energize and charge the motivation level of nurses who have reached a plateau position in terms of job promotions.

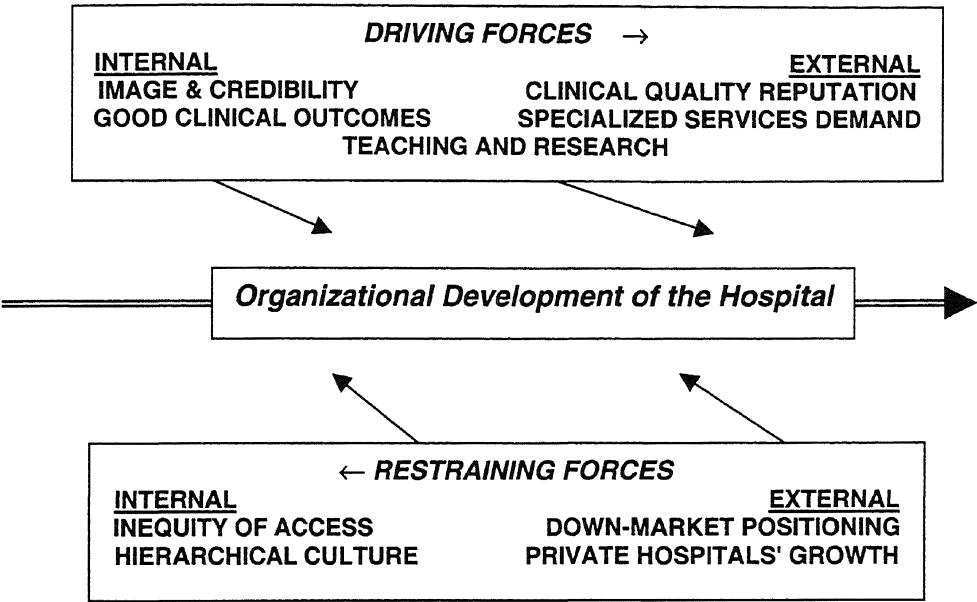
6.7: SWOT ANALYSIS FRAMEWORK FOR THE HOSPITAL

The findings and discussion provide a data set for a preliminary Strengths, Weaknesses, Opportunities and Threats Analysis (SWOT) of the hospital. From an Organizational Development (OD) perspective, the strengths and opportunities could be the internal and external driving forces and the weaknesses and threats the internal and external restraining forces respectively.

The following figure presents the SWOT as Driving and Restraining forces for the hospital with reference to the factors taken up in this study. Other factors like the research and teaching activities may also be contributing to the overall SWOT analysis. But they have not been considered in this analysis. Therefore this figure has to be interpreted within the framework of determinants of inpatient service quality taken up for this study.



Figure 6.7: S W O T Analysis showing Driving and Restraining Forces for the Hospital



Source: Original - constructed from this study

Strengths / Internal Driving Forces:

The hospital's greatest strength is its *image and credibility*. The findings have consistently revealed that the consumers rate the hospital very high on the credibility and competence of the caregivers. The diagnostic services are perceived to be superior and there is a very positive connotation associated with *teaching and research affiliation* of the institution. The presence of medical students is also seen as contributing to greater attention and care of patients.

Treatment at this hospital leading to *positive or good clinical outcomes* is another strength as shown from the findings. This factor gains further strength considering the referral status of this hospital and that severely ill patients are sent here for inpatient care from other hospitals.



Opportunities / External Driving Forces:

This hospital's ***reputation for quality of clinical services*** is an opportunity for enhancement of its referral status as well as capitalizing on this factor for better pricing decisions in the future. Enhancement of referral status could provide opportunities for treating more challenging health conditions and developing the infrastructure for this purpose. Training inputs to students would also be enriched as a consequence. Appropriate pricing is essential for maintaining the facilities, achieving better cross-subsidization and better income generation against the backdrop of shrinking government funds / grants.

The findings show a ***high demand for specialized facilities*** like Trauma Care, Fertility Clinics and Cardiac Care. Developing these facilities is not only an opportunity for providing a higher level of medical services, but also contributing to knowledge through research and training. Starting of higher level postgraduate courses could also be made possible.

Weaknesses / Internal Restraining Forces:

There is an inadequacy and ***inequity in access*** as seen in the case of special wards. Inadequacy of wards that can attract a paying clientele is disadvantageous in the long run. Access may also be limited in general by the lack of other resources and an inadequate customer / employee focused process orientation and a predominantly ***functional hierarchical culture*** with very little autonomy for innovation and lack of incentive for better performance.

Inequity is also expressed in the findings showing that responsiveness and communication is significantly better if a patient knows a hospital employee. This can lead to negative word-of-mouth and undesirable bias in service provision.



Threats / External Restraining Forces:

A "***Down-market Positioning***" of the hospital as a result of decreased access to paying clientele could lead to permanently freezing demand patterns at the very low purchasing power level. This in turn could lead to dwindling of income generation and consequent pruning of services for which equipment infrastructure has been built but maintenance expenses have dried up. Downgrading of services could result in inadequacy of training opportunities in the use of the latest techniques and treatment of non-routine conditions. Such a situation can also lead to a low-quality spiral with providers just meeting the lower expectations of the under-privileged clientele. An unequal provider-patient dyad is the starting point for low quality if the patient has low bargaining power.

The rapid ***growth of private sector hospitals*** in the area could result in weaning away even the existing paying patients and consolidate the position of this hospital as that meant only for the non-paying clientele. Although the public-sector hospital in general, has been established to serve with a non-profit and social cost-benefit motive, social responsibility seen as "enlightened self-interest" demands that the hospital has to remain in existence and act as a check against possible exploitation by private providers. Income generation is thus an essential condition for existence and survival. Teaching and research affiliation places an additional responsibility for knowledge creation and training and hence makes the healthy economic life of the hospital mandatory.

CHAPTER CONCLUSION:

The key points that emerge from the discussion of the findings are:

a) consumers consider interpersonal rather than technical quality important; b) consumer involvement is a very important variable that can influence quality perceptions as well as clinical outcomes and has to be enhanced; c) knowing a hospital employee results in better quality services



- this point goes against the principle of equity of access and needs to be addressed; d) the hospital's good reputation for its clinical service quality and superior diagnostic abilities could be capitalized; e) there is an expressed need for a process-based and networking culture to enhance the ability of the hospital to respond to innovations in the environment; f) motivation levels of nurses have to be enhanced.

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