

Comparison of patient, staff, and administrator perspectives of service quality in healthcare

Dr. Jerome Christia

Coastal Carolina University

Dr. Aaron Ard

University of South Carolina – Salkehatchie

The size and growing significance of the services industry in developed markets like the US has spawned a sizeable body of academic research addressing a variety of factors such as service quality and its dimensions. The service sector represents an overwhelming proportion of total employment and gross domestic product in the United States. Marketers, managers, and academics continue to research, analyze, and describe strategies for which organizations can reap competitive advantages. Providing superior quality in service experiences is an effective approach to acquire such an advantage. In the face of increasing competition, it is in an organization's best interest to provide customers with the best service possible. This paper examines differences in perspectives of service quality in a medical office. Three key stakeholders – administrators, staff, and patients are analyzed to evaluate differences in priority of the SERVQUAL dimensions of reliability, assurance, tangibles, empathy, and responsiveness. This study finds that there are different views on the importance of service quality across administrators, staff, and patients for a medical service.

SERVQUAL, service quality, perceptions, quality, healthcare service

INTRODUCTION

A firm grasp of service quality antecedents and consequences is imperative in profit oriented businesses, as well as, nonprofit institutions. While becoming increasingly important, this principle is applicable across all industries and organizations. Understanding consumer expectations is a necessary tool to defining and creating successful marketing strategies and executions. Many providers with help from the research community are beginning to realize that providing customer satisfaction is a key element in strategy and a crucial determinant of long-term viability and success (Andaleeb, 1998). This study will examine some of the existing issues on consumer service quality, and suggest practical and theoretical relevance.

This paper examines the perceptions of patients, staff, and administrators to provide insight into the prioritization of service quality dimensions in a healthcare setting. Service performance is inherently more variable than product performance, making service performance less predictable than product performance (Folkes and Patrick, 2003). It is unclear whether consumers assume the same degree of similarity among service providers. One of the most popular tools used to measure service outcomes is the SERVQUAL measure.

SERVICE QUALITY IN HEALTHCARE

Service quality remains one of the most significant areas of study in marketing. This impactful concept is especially significant to marketers for a number of reasons. Service quality helps determine the success or failure of service providers. The implementation of service quality influences the rate of acceptance of the services provided, while encouraging positive referrals. Several studies have shown that service quality is a key determinant of market share and return on investment as well as cost reduction (Parasuraman, Zeithaml, and Berry 1985).

An extensive review of existing literature on the concept of service quality provides insight on a variety of influencers of service quality. Many practitioners argue there is no single predictor of service quality. Given the failure to find empirical support for a concept of service quality that is generalizable over a wide range of services, it is not surprising that differing profiles of consumers would be found for different types of services.

Service quality in health care has been defined as the “provision of appropriate and technically sound care that produces the desired effect” (McAlexander, Kaldenberg, & Koenig, 1994). More recently, however, the definition has come to include the delivery of the service and how it relates to customer needs and expectations (Self & Sherer, 1996). In a health care context, patients’ expectations are formed as a result of previous experiences with the provider, word-of-mouth communication, social media, marketing communications, and personal needs (Parasuraman, Zeithaml, & Berry, 1985).

Generally, Parasuraman, Zeithaml, and Berry (1988) have defined the service quality concept in terms of five major dimensions:

- Tangibles: Physical facilities, equipment, personnel, and communication materials.
- Reliability: Ability to perform the promised service dependably and accurately.
- Responsiveness: Willingness to help customers and to provide prompt service.
- Assurance: Knowledge and courtesy of employees and their ability to convey trust and confidence.
- Empathy: Providing caring, individualized attention to customers.

Comparison of patient

To adequately study this phenomenon, several criteria must be taken into consideration. Since the seminal piece by Parasuraman, Zeithaml, and Berry (1988), the SERVQUAL measurement tool has been applied in fields that span the service industry spectrum. One very interesting application is in the areas of marketing and managing medical services. There have been several service quality studies in the medical field. According to Lal, Vij, and Jain (2014), the increased emphasis on quality in medical services is attributable to benefits which both patients and medical service facilities may acquire from providing quality medical service. SERVQUAL has been shown to be useful in revealing the differences between patients' preferences and their actual experience, thus identifying areas in need of improvement (Pakdil & Harwood, 2005).

Patients, service providers and other parties involved in the process of health care service delivery, understand and describe service quality in different ways. Different perspectives on health care quality lead to different expectations and different methods of quality measurement. This paper will include a conceptual overview of descriptions of three major perspectives on health care quality: the patient, staff, and administrator points of view.

PATIENTS PERCEIVED HEALTHCARE QUALITY

Patients' expectations about their health care often differ from those of healthcare providers and managers. Research indicates that patients tend to evaluate healthcare quality based on the responsiveness to their needs. Most patients define quality as efforts of physicians to do everything possible for a patient (Piligrimiene and Buoninoine, 2008). According to McGlynn (1997), medicine has made remarkable advances over the past century, which leads patients to expect that modern medicine is able and willing to solve most health problems; medications can cure any number of physical and psychological problems; surgery can undo the damage caused by genetic factors, lifestyle choices, or accidents; and immunizations can prevent the development of diseases that until recently meant death or disability. For example, shorter visit lengths, which reduce the cost of providing ambulatory care, may have a negative effect on patients' ability to participate in making choices about their care (Piligrimiene and Buoninoine, 2008). On the other hand, patients cannot evaluate many technical aspects of health care quality. Physicians can provide a high level technical quality but still be rated low by patients because of the lack of humanity, responsiveness or satisfaction.

Studies suggest that the most important elements of quality for patients include effectiveness, accessibility, interpersonal relations, continuity and tangibles. In addition, a critical factor affecting service quality evaluation is the feeling of trust. Trust has also been defined as an emotional characteristic, where patients have a comforting feeling of faith or dependence in a care provider's intentions with common dimensions such as competence, compassion, privacy and confidentiality, reliability and dependability and communication (Pearson and Raeke 2000). Fundamentally, trust is a feeling of certainty that a person or a thing will not fail and is often based on inconclusive evidence. Trust is crucial since obstetrics has one of the highest incidents of patient-initiated malpractice cases, causing many obstetricians to limit the care they provide or leave the field (Rosenblatt et al. 1990, Bernstein 2005). Patient's trust has been linked to important organizational and economic factors such as decreases in the possibility of a patient leaving a care provider's practice and withdrawing from health plans (Pearson and Raeke 2000).

Comparison of patient

STAFF PERCEIVED HEALTHCARE QUALITY

There have been several service quality studies in the medical field. The SERVQUAL approach allows healthcare teams to evaluate patient experience, while accounting for variation in their expectations and priorities (Garrard and Narayan 2013). There are many structured and unstructured efforts to measure various components of quality for patients, staff, and providers. Some argue that healthcare systems lack a unified process for assessing the various elements of quality. It is not surprising knowing the complexity of healthcare services and difficulty of service quality evaluation (Piligrimiene and Buciuniene, 2008).

In designing a coordinated strategy, one must ensure that the complex dynamics of healthcare delivery, the varying levels at which care might be evaluated, and the different perspectives of the key stakeholders in the system which includes staff are adequately represented (Piligrimiene and Buciuniene, 2008).

As a general rule, negative information about a product's attributes influences brand perceptions more than positive information (Herr, Kardes, and Kim 1991). In contrast to the negativity bias for products, researchers propose a positivity bias for services. Positive information about an individual service provider's characteristic leads the consumer to infer that the firm's other employees share those same positive characteristics to a greater extent than does negative information.

ADMINISTRATORS' PERCEIVED HEALTHCARE QUALITY

For this paper, administrators include physicians/partners and managers. The quality of the interaction between physician and patient depends on several elements in their relationship: quality of communication, physician's ability to treat the patient with "concern, empathy, honesty, tact and sensitivity" (Donadedian, 1988). Physicians also tend to balance between efforts to control costs, their own judgment about the best way of treatment and demand to consider the values of patient while making the treatment choices (McGlynn, 1997). Healthcare professionals (physicians) tend to define quality in terms of the attributes and results of care, and this definition emphasizes the technical excellence with which care is provided and the characteristics of interactions between provider and patient (Piligrimiene and Buciuniene, 2008). For physicians and other healthcare providers measurement of quality has typically been driven by medical outcomes. However, outcomes indicative of quality may differ for a patient and physician. Management does not always correctly understand what customers want (Chowdhury, 2009).

Physicians are caught between efforts to control costs, their own judgment about the best course of treatment for a patient, and demands that patients' values be reflected in making treatment choices. These three influences do not always lead to the same conclusion.

Hypotheses:

H1: There is a difference in priority for SERVQUAL within the patients, staff, and administrators.

H2: There is a difference in priority for SERVQUAL across the patients, staff, and administrators.

METHODOLOGY

Comparison of patient

Participants were surveyed in a large south-eastern suburban area in the United States through an office manager who facilitated data collection. Respondents were instructed to distribute 100 points across the five SERVQUAL dimensions. Each dimension was given a score 0-100, so that the total score was 100 for the five variables. One-way ANOVA (Analysis of Variance) testing was used to detect any statically significant differences in the importance of patient perceptions regarding factors that affect service quality in a large obstetrician and gynecological medical practice (Moore, McCabe, Alwan, & Craig, 2016). A maximum variation sampling framework was used in the theoretical sampling tradition. In this framework, participants were not included because of their representativeness but for their relevance to the research question (Patton, 2001). Participants represented three major groups of obstetric system users: (1) patients (2) staff and (3) administrators (physicians/partners and sr. managers). The sample sizes of $n = 363$ for patients, $n = 19$ for professional staff and $n = 10$ for administrators gives adequate statistical power to infer any difference in ratings of perceptions of service quality are not the result of chance.

Data of patient, staff and administrator ratings of perceptions of service quality were collected on five dimensions: Tangibles- Appearance of physical facilities, equipment, personnel, and communication materials; Reliability- Ability to perform the promised service dependably and accurately; Responsiveness- Willingness to help customers and to provide prompt service; Assurance- Knowledge and courtesy of employees and their ability to convey trust and confidence; Empathy- Providing caring, individualized attention to customers. These dimensions were analyzed between different stakeholder status measures (patients, professional staff and administrators) using the ANOVA (Comparison of Means) function in the statistical software package SPSS.

Table 1 below shows the sample size for each stakeholder group as well as the mean response rating of perceptions of service quality on each of the five dimensions. Table 1 lists the statistically significant ratings by stakeholder status factor and service dimension. The results of the test of each hypothesis are presented.

RESULTS

H1: There is a difference in priority for SERVQUAL within the patients, staff, and administrators.

H1 is supported. The most important service quality dimension for administrators is Assurance, which refers to knowledge and courtesy of employees and their ability to convey trust and confidence. The most important service quality dimension for staff is Reliability, which refers to the medical office's ability to perform the promised service dependably and accurately. The most important service quality dimension for patients is Reliability, which refers to the medical office's ability to perform the promised service dependably and accurately. Patient ratings on the importance of Reliability were significantly different from their ratings on the other service dimensions ($p < 0.05$).

H2: There is a difference in priority for SERVQUAL between the patients, staff, and administrators.

Comparison of patient

H2 is supported. Patients, staff, and administrators tend to rate all dimensions regarding quality similarly except Empathy, which refers to providing caring, individualized attention to customers. Staff ratings on the importance of Empathy are statistically significantly lower than the patients or administrators surveyed ($p < 0.10$).

DISCUSSION

This study reveals that there are statistical differences in priority for administrators, staff, and patients for service quality perceptions. There are a number of theoretical and practical implications for planning, implementing, and evaluating the service quality domain. Ultimately, there are strategic applications for marketing concepts such as segmentation, targeting, and positioning. In addition, there are lessons for marketing communications and customer service. Overall, there are implications for marketing management, strategy and planning, decision-making processes, market segmentation, target marketing and product positioning.

The five dimensions of service quality vary across the three key stakeholders. This research provides evidence that Assurance is the key dimension of service quality for administrators. This places emphasis on medical offices properly training employees to be able to create feelings of trust and confidence. However, this differs from the top service quality dimension for staff and patients. The lowest ranking service dimension for administrators is Tangibles and the physical elements of the service experience. For staff and patients, the focal point is on Reliability and the medical office's ability to perform the promised service dependably and accurately. Yet, the least important service dimension for staff is Empathy, while it is Tangibles for patients.

Lately, there has been a movement to integrate the three perspectives. To narrow patient and provider gaps, Chowdhury (2008) suggests conducting continuous market research to find out customers' requirements and maintain relationship marketing to build up customer loyalty. The health care service quality evaluation must find a way, which encompasses expectations and needs of every party involved (Piligrimiene and Buoninoine, 2008). Communication is the key to understanding these differences in perspective to minimize operational costs, while maximizing service quality. Management might correctly perceive what customers want but sometimes they are unable to design customer need and want based services and a standard performance (Chowdhury 2008). It is now possible to combine patient perceptions with quality measures from other sources, such as clinical administrative databases or medical record review, to achieve a more comprehensive and useful measure of overall quality (Bowers and Kiefe, 2002).

REFERENCES

- Andaleeb, S. S. (1998). Determinants of customer satisfaction with hospitals: A managerial model. *International Journal of Health Care Quality Assurance*, 11(6), 181–187.
- Bowers M., Swan J., & Koehler W. (1994). What attributes determine quality and satisfaction with health care delivery? *Health Care Management Review*, 19(4), 49-55.
- Chowdhury, M. U. (2008). Customer expectations and management perceptions in healthcare services of Bangladesh: An overview. *Journal of Services Research*, 8(2), 121-140.
- Donabedian, A. (1988). The quality of care: How can it be assessed? *Journal of the American Medical Association*, Spring, 175-192.
- Folkes V., & Patrick V. (2003). The positivity effect in perceptions of services: seen one, seen them all? *Journal of Consumer Research*, 30(1), 125-137.
- Garrard, F., Ridd, M., Narayan, H., & Montgomery, A. (2015). Medical decision making: decisions, choice and shared decision making in antenatal clinics: An observational study. *Patient Education and Counseling*, 98, 1106-1111.
- Herr, P. M., Kardes, F., & Kim J. (1991), Effects of word-of-mouth and product attribute information on persuasion: An accessibility-diagnostics perspective. *Journal of Consumer Research*, 17(March), 454-62.
- Lal, J., Vij, M., & Jain, S. (2014). Do demographics influence customer service quality perceptions? A comparative study of Indian and foreign banks. *Journal of Services Research*, 14 (2), 75-105.
- Mattila, A. S. (2001). The impact of relationship type on customer loyalty in a context of service failures, *Journal of Service Research*, 4(2), 91-101.
- McAlexander, J. H., Kaldenberg, D. O., & Koenig, H. F. (1994). Service quality measurement. *Journal of Healthcare Marketing*, 14(3), 34–40.
- McGlynn, E. A. (1997). Six challenges in measuring the quality of health care. *Health Affairs*, May/June, 7-21.
- Moore, D. S., McCabe, G. P., Alwan, L. C., & Craig, B. A. (2016). *The practice of statistics for business and economics*. New York: W.H. Freeman and Company, a Macmillan Education imprint.
- Pakdil, F., & Harwood, T. N. (2005). Patient satisfaction in a preoperative assessment clinic: An analysis using SERVQUAL dimensions. *Total Quality Management*, 16(1), 15–30.
- Parasuraman, A., Zeithaml, V., & Berry, L. (1985). A conceptual model of service quality and its Comparison of patient

implications for future research. *Journal of Marketing*, 49(4), 41-50.

Parasuraman, A., Berry, L., & Zeithaml, V. (1988), SERVQUAL: A multiple-item scale for measuring consumer perceptions of service quality, *Journal of Retailing*, 64 (1), 12-40.

Patton, M.Q., 2001. *Qualitative research and evaluation methods*. 3rd ed. Thousand Oaks, CA: Sage.

Pearson, S.D. & Raeke, L.H., 2000. Patients' trust in physicians: many theories, few measure, and little data, *Journal of General Internal Medicine*, 15, 509–513.

Piligrimiene, Z., & Buciuniene, I. (2008). Different perspectives on health care quality: Is the consensus possible? *Engineering Economics*, 56(1), 104-111.

Rosenblatt, R.A., et al., 1990. Why do physicians stop practicing obstetrics? The impact of malpractice claims. *Obstetrics & Gynecology*, 76 (2), 245–250.

APPENDIX A

Table 1

One-Way ANOVA-Comparisons of Mean Difference (Between Groups and Within Groups) by Stakeholder Status

<i>Item</i>	<i>Means</i>		
	Administrators	Staff	Patients
N	10	19	363
<i>Service Quality Dimensions</i>			
Tangibles	16.3	19.3	17.7
Reliability	19.2	22.9	23.4
Responsiveness	20	20.3	19.1
Assurance	23.5	21.3	20.5
Empathy	21	16.2	19.8

Significance * $p < 0.10$, ** $p < 0.05$

Comparison of patient