CHAPTER NUMBER THREE

REVIEW OF LITERATURE

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An attempt has been made by the research scholar to collect various kinds of information and data from the available Books, Journals, Business Newspapers, Reports published by various State and the Central Government of India as well as by Expert Agencies and the researcher has also downloaded material using various websites and search engines.

A review of literature has been subdivided in two major parts as follows.

(i) Review of Literature on Customers' Satisfaction.

(ii) Review of Literature on Patients' Satisfaction.

The researcher has made an attempt to review available empirical research studies being undertaken by various researchers that had focused on customers' satisfaction and patients' satisfaction as follows (List of the name of the researchers carried out various research studies on patients' satisfaction summarized in Appendix I to Appendix X).

3.1 A BRIEF REVIEW OF LITERATURE ON CUSTOMERS' SATISFACTION:

A brief outline of literature on customers' satisfaction has been given as follows.

Satisfaction is a person's feeling of pleasure or disappointment resulting from comparing a product's perceived performance or outcome in relation to his or her expectations. Whether the buyer is satisfied after purchase depends on the products or service performance in relation to the buyer's expectations that is satisfaction is a function of perceived performance and expectations. If the performance falls short of expectations, the customer is dissatisfied. If the performance matches the expectations, the customer is satisfied. If the performance exceeds the expectations, the customer is highly satisfied or delighted. Those who are highly satisfied are much less ready to switch. High satisfaction or delight creates an emotional bond with the brand, not just a rational preference (Philip Kotler, 2000).[1]

Customer satisfaction is the extent to which a firm fulfills a customer needs, desires and expectations. A manager who adopts the marketing concepts sees customer satisfaction as the path to profits. A consumer is likely to be more satisfied when the customer value is higher that is when benefits exceed costs by a larger margin. Since consumer satisfaction is the objective of marketer, marketing's effectiveness must be measured by how well it satisfies consumers (William D. Perreault, 2002).[2]

According to William J. Stanton et. al., (1994) quality has always been important to consumers. And so for marketer, customer satisfaction is the best measure of quality. In a competitive environment, the ultimate indication of satisfaction is whether or not the costumer returns to buy a product a second, third or fourth time.

However, a firm can't afford to gamble that its marketing decisions are correct and then wait for repeat purchases to confirm or reject those judgments. Instead, managers realize that satisfaction is determined by how closely experience with a product meets or exceeds a customer's expectations. Therefore, marketers must do two things first; ensure that all marketing activities such as the price of a product, the claims made for it in advertising, and the place in which it is sold, contribute to creating reasonable expectations on the part of the customer. Second, eliminate variations, in customer's experiences in purchasing and consuming the product (William J. Stanton et. al., 1994).[3]

Customer expectations of service play an important role in the purchase decision. 'Service is the spectrum of activities designed to enhance customer expectations and enjoyment of product benefits. The marketing plan must cover the four main components or areas of customer service are customer education; employee education; costumer complaint administration, and cost levels of providing services (Bernard Katz, 2004).[4]

Sheila Payne (2005) has discussed about how to keep customers happy. She has emphasized on maintaining reliable customer service and has also provided guidance on developing positive working relationships and on solving problems and initiation and evaluation of changes on customers' behalf. Customers come in all shapes and sizes, all temperaments and moods. Keeping customers happy is not always easy. But, no matter how a marketer or businessman feel, marketer has to be positive and professional at all times. If marketer does not know how to help a customer, s/he should know whom to ask in the staff to handle customer. Knowing own company's structure is important so that marketer knows exactly who works, in which department and what they do (Sheila Payne, 2005).[5]

According to a comprehensive review conducted by Yi, (1993) customer satisfaction has been defined in two basic ways as either outcome or as a process. The outcome definition characterize satisfaction as the end-state resulting from the consumption experience and alternatively, satisfaction has been considered as a process, emphasizing the perceptual, evaluative and psychological process that contribute to satisfaction, and these definitions varied with regard to their level of specificity. Various levels include satisfaction with a product; satisfaction with a purchase decision experience; satisfaction with a performance attribute; satisfaction with a consumption experience; satisfaction with a store or institution; and satisfaction with a pre-purchase experience (Terry G. Vavra, 1998).[6]

Even the culture, particularly national culture, is related to service quality and interpersonal relationship expectations and long-term buyer-seller relationships. Such relationship is the result of satisfaction from each other. Individualism/collectivism, power distance, and long-term - orientation are linked to perceptions and relational formation patterns across cultures. To ignore the impacts of cultural differences is to run a because that marketing practices in one country may prove to be insufficient in another (Satya Dash, 2002).[7]

Kang Duk Su and Maryam M. Khan (2003) investigated the service quality expectations of tourists visiting Cheju Island in SouthWest Korea. It showed that such tourists tend to expect more of those services that are courteous and informative, and conveyed a feeling of trust and confidence (Kang Duk Su and Maryam M. Khan, 2003).[8]

Philip E. Pfeifer et. al. (2004), undertook an empirical study with a major purpose to create and clarify differences between customer lifetime value and customer profitability by offering concise definitions for both in finance and accounting term. He attempted to eliminate this confusion by offering good, concise, acceptable, inclusive, and consistent definitions and suggested short, clear and specific definitions. He defined customer profitability (CP) as the difference between the revenues earned from and the costs associated with the customer relationship during a specified period, whereas customer lifetime value (CLV) was described as the present value of the future cash flows attributed to the customer relationship (Philip E. Pfeifer et. al., 2004).[9]

Praveen K. Kopalle and Donald R. Lehmann (2002), conducted a study based on 200 consumers to measure consumers' expectations on marketing-mix variables and optimal decisions of the firm. The Results showed that the purchase intentions, and satisfaction with the last purchase had a much stronger impact on future intentions, and failure to consider the customer expectations setting process may lead to non-optimal firm decisions (Praveen K. Kopalle and Donald R. Lehmann, 2002).[10]

According to Atul Parvatiyar, and Jagdish N. Sheth (2001) customer satisfaction can also be ensured through focusing on customer relationship management philosophy. They defined customer relationship management (CRM) as a comprehensive strategy and process of acquiring, retaining, and partnering with selective customers to create superior value for the company and the customers. (Atul Parvatiyar, Jagdish N. Sheth, 2001).[11]

Tavite M. Latu, Andre M. Everett (2000) summarized the literature on visitor satisfaction and its measurement in tourism in New Zealand. They concluded that an extensive list of techniques exists to help the service provider to hear the voice of the customer. It provided recommendations for different satisfaction assessment approaches which included, listening the voice of visitors; focus groups; visitor satisfaction cards; questionnaires; review of journals, magazines, and newspapers; study of guidebooks, interviewing relevant professionals; interviewing of guides; direct research; and benchmarking (Tavite M. Latu, Andre M. Everett, 2000).[12]

Jantawan Noiwan et. al. (2005) evaluated computer attitude and computer self-efficacy of 151 Thailand undergraduate students. They found that students' possess moderately positive attitudes on computer technology and neutral confidence in using computer applications which reflected their consistent satisfaction for computer technology (Jantawan Noiwan et. al., 2005).[13]

Moonkyu Lee, Francis M. Ulgado (2000) examined determinants of international customer loyalty with reference to an Internet shopping mall under the assumption that consumers performed a cost/benefit analysis when deciding whether or not they want to be regular customers. The study conducted that potential determinants of customer loyalty were based on the service quality, transaction cost, and switching cost literature (Moonkyu Lee, Francis M. Ulgado, 2000).[14]

Tony Tricker (2003) showed how students' expectations had constantly changed since the 1970s in UK. Students of Higher Education (HE) increasingly perceived themselves to be customers of a service. Students' and parents' expectations were high and covered flexibility and choice in the delivery of education; access to cutting edge technology; a two way communication process between themselves and with the university and the learning experience as well as accurate information about their courses, assessment procedures, complaints process, etc., and finally honesty with respect to whether their needs can be met or not (Tony Tricker, 2003).[15]

A study paper discussed about importance of using satisfaction surveys for achieving a competitive advantage. The value of satisfaction was often underestimated by many businesses. Loyal customers and employees affect an organization's success, which is difficult to quantify and loyal customers induces business by increasing their market share. (SPSS White Paper, 1995).[16]

The Government's customer service revolution started in 1993 with a recommendation from Vice President Gore's (USA) National Performance Review team, followed by President Clinton's Executive Order, Setting Customer Service Standards. In 1995, President (USA) Clinton reinforced his order to put customers first. It left no doubt that the goal was a revolution in how Government does business so that customers are the focus. To comply with this directive, teams of Government agencies also embarked on a series of benchmarking studies. Some of the valuable lessons learnt during this process were, make it easy for customers to complain and in turn customers will make it easy for business to improve; respond to complaints quickly and courteously with common sense to improve customer loyalty; resolve complaints on the first contact and save money by eliminating unnecessary additional contacts and build customer confidence; technology utilization is critical in complaint handling systems, and recruit and hire the best individuals for customer service jobs (National Performance Review, USA- 1996).[17]

If organizations want to build service quality, they must have systems that work, and must understand customers' expectations, and must be willing to let train people make decisions with few restrictions. Its suggested guidelines included viz., ask customers to compare the services provided by company with the competitors' services and other organizations to help company benchmark for its services; ask customers' to contact people to compare the company with other organizations; build teamwork throughout the organization and develop real partnerships with customers whenever possible; train all employees on the technical information about company's products and services.

It also suggested to develop good communications skills and interpersonal skills throughout the organization; establish good external measures of service quality at every level of the organization and between the departments (Scott J. Simmerman, 1995).[18]

Lt Col S Chaudhury and Lt Col A Banerjee (2004) assessed the job satisfaction of medical officers of the Armed Forces in Medical College, Pune and their results suggested that overall there was a low level of job satisfaction among the medical officers. There was no significant difference in the level of job satisfaction in the three groups. It was concluded that job satisfaction is a multi-dimensional phenomenon where it is not easy to assign one factor as the sole determinant of satisfaction/dissatisfaction with the job (Lt Col S Chaudhury, Lt Col A Banerjee, 2004).[19]

Subhajyoti Ray and V. Venkata Rao (2005) assessed the change in service quality as a result of e-Government project implementation. The authors have studied the automated civic services system implemented by the Municipal Corporation of the city of Ahmedabad, Gujarat State. They proposed the analytical hierarchy approach as a tool that can be used to assess e-Government induced changes in public service quality. There were significant advantages of using the method proposed by study. The method provided a very convenient tool to e- Government project managers to monitor the progress made and need to focus on areas where improvement was required (Subhajyoti Ray, V. Venkata Rao, 2005).[20]

Terence A. Oliva et. al. (1992) examined the issue in terms of customer service and noted that simply investing in greater service delivery may not return the cost of the additional investment. It proposed a Catastrophe Model for analyzing customer's complex behaviour in a way that can lead to the development of more accurate service strategies through an understanding of the relationships among customer-transaction costs, satisfaction, and purchase loyalty. The model was applied to a small service quality customer dataset provided by General Electric Supply. Research indicated that depending on transaction costs, the relation between customer satisfaction and loyalty can be nonlinear, at least for some facets of service. It brought out an important implication for service strategy and decisions on how to deploy a limited budget across different opportunities to enhance service given that competitors were making similar decisions. (Terence A. Oliva et. al., 1992).[21]

Richard L. Oliver (1980) provided a more substantial and simultaneous test of the relationships among expectation, disconfirmation, satisfaction, and the traditional criteria of attitude and purchase intention that has been performed to date. It suggested that the effects of expectation and discrepancy perceptions may be additive. Specifically, expectations were thought to create a frame of reference about which one makes a comparative judgment. Thus, outcomes poorer than expected (a negative disconfirmation) were rated below this reference point, whereas those better than expected (a positive disconfirmation) were evaluated above this base. The study offered a model which expressed consumer satisfaction as a function of expectation and expectancy disconfirmation.

Satisfaction, in turn, was believed to influence attitude change and purchase intention. It was summarized that satisfaction is to be seen as a summary psychological state resulting from emotions surrounding disconfirmation or confirmation of the consumers' expectations or prior feelings of a service and thoughts about the actual consumption experience. It suggested that satisfaction ultimately impacts one's overall attitude towards future consumption behavior (Richard L. Oliver, 1980).[22]

Peter J. Danaher, Vanessa Haddrell (1996) studied contrasted performance, disconfirmation and satisfaction scales on six criteria to determine their relative merits for measuring customer satisfaction. These criteria were viz., reliability, convergent and discriminant validity, predictive validity, skewness, face validity and managerial value. In all, but one of these criteria, namely, predictive validity, the disconfirmation scale was superior to both the performance and satisfaction scales. Researcher were able to attribute the inferior predictive validity of the disconfirmation scale to the small number of points (three) and showed that a five-point disconfirmation scale should have higher predictive validity. The Study revealed that the disconfirmation scale appeared to be better than both the performance and satisfaction scales (Peter J. Danaher, Vanessa Haddrell, 1996).[23]

Shu Tian-Cole, John L. Cromption (2003) suggested a model which was developed to integrate and reconcile various differences. The central constructs of this model were quality of performance; quality of experience; overall service quality; overall satisfaction; and destination selection intention. The results of this empirical test of the model verified the existence of service quality and visitor satisfaction at both the transaction and global levels. At the transaction level, quality of performance contributed to quality of experience; while at the global level, overall satisfaction influenced overall service quality. Both, overall service quality and overall visitor satisfaction were found as having directly influenced visitors' future destination selection intentions, and were confirmed as being different constructs (Shu Tian-Cole, John L. Cromption, 2003).[24]

Michael A. Richard (2000) offered a multidimensional tool, SERVQUAL, to assess consumer satisfaction which emphasized on the discrepancies between individual expectations and perceptions of services received. Several studies have indicated a strong relationship between consumers' perception of satisfaction and attrition from counseling. This article was intended as a step in the process of implementing research which included areas specific to rehabilitation service consumers,; to identify the factors they utilize when arriving at opinions of satisfaction or dissatisfaction; and to determine how their opinions may or may not relate to premature termination. It suggested that SERVQUAL instrument addresses methodological problems and thus may be a useful approach to determine consumer satisfaction with an array of rehabilitation services (Michael A. Richard, 2000).[25]

Mark M. Davis, Thomas E. Vollmann, (1990) had developed a framework for integrating the operations management and marketing approaches within a service operation. It focused on customer satisfaction with waiting time, with a goal of providing improved satisfaction for a given level of resources. An application of this methodology was provided in two different locations of a major fast food chain where waiting time was an important determinant in the consumers' firm selection process. Its results suggested that customer satisfaction was inversely related to waiting time that meant the longer a customer waits the less satisfied or dissatisfied the customer for the service. It also revealed that time of day and store location significantly affectes the relationship between waiting time and customer satisfaction, but the type of the day that is weekday or weekend did not. Considering the criticality of time, customers at lunch in fast food would be more dissatisfied with longer waiting times than customers at slack and dinner times. With this approach, the manager can identify those variables unique to his or her operation that affect the relationship between customer satisfaction and specific operational parameter, such as speed of service (Mark M. Davis, Thomas E. Vollmann, 1990).[26]

Stephen W. Brown, Teresa A. Swartz (1989) explored the concept of professional service quality and its evaluation from both the provider and client perspectives, using medical services as the primary setting. The gap analysis was used as an appropriate approach for examining the evaluation of a professional service. It concluded that inconsistencies in expectations and experiences can and do have an adverse effect on the evaluation of service performance. Incongruencies could lead to the patient offering negative word of mouth comments about the physicians and his or her practice and vice a versa. Once inconsistencies have been identified, strategies and tactics for achieving more congruent expectations and experiences can be initiated. Compatible expectations and experiences can be achieved by altering the provider's behaviour and expectations and/or by altering the client's expectations and experiences. Greater consistency, in turn, leads to amore positive service encounter and enhances the likelihood that the experience will evolve into a longer term client-provider relationship (Stephen W. Brown, Teresa A. Swartz, 1989).[27]

Many individual companies and some industries monitor customer satisfaction on a continual basis, but Sweden is the first country to do so on a national level by using the new index Customer Satisfaction Barometer (CSB) that measures customer satisfaction, which is intended to be complementary to productivity measures. Whereas productivity basically reflects quantity of output, CSB measures quality of output as experienced by the buyer. Claes Fornell (1992), reported the results of a large-scale Swedish efforts to measure quality of the total consumption process of customer satisfaction, and the results indicated that industries selling homogeneous products to a homogeneous market or differentiated products (services) to a heterogeneous market typically had higher CSB than other industries.

An implication from examining the relationship between market share and customer satisfaction by a location model was that satisfaction should be lower in industries where supply was homogeneous and demand heterogeneous. Satisfaction should be higher when the heterogeneity/homogeneity of demand was matched by the supply. Likewise, industries in general were found to have a high level of customer satisfaction if they were highly dependent on satisfaction for repeat business. The opposite was found for industries in which companies had more captive markets (Claes Fornell, 1992). [28]

Priscilla A. Labarbera, David Mazursky (1983) offered a simplified cognitive model to assess the dynamic aspect of consumer satisfaction/dissatisfaction in consecutive purchase behavior. It revealed that satisfaction was found to have a significant role in mediating intentions and actual behavior. The asymmetric effect found demonstrated that repurchase of a given brand was affected by lagged intention whereas switching behavior is more sensitive to dissatisfaction with brand consumption. An attempt to predict repurchase behavior on the basis of the investigated cognitive variables yielded weak results. However, repurchase predictions were improved when the model was extended to a multipurchase setting in which prior experience with the brand was taken into account (Priscilla A. Labarbera, David Mazursky, 1983). [29]

Gilbert A. Churchill (1979) discussed an approach which outlined how the goal of development of better measures can be achieved. It aimed to outline a procedure which can be followed to develop better measures of marketing variables and the framework was developed to unify and bring together in one place the scattered bits of information on how one goes about developing improved measures and how one assesses the quality of the measures that have been advanced Gilbert A. Churchill, 1979). [30]

Moreno Muffatto, Roberto Panizzolo (1995) developed a framework for customer satisfaction and provided a detailed description of the relationship structure between the different elements of the organizational structure. Starting from the consideration that customer satisfaction is an interfunctional concept, this framework sought to integrate all aspects into one model. This study was divided into two sections which, respectively, dealt with the key evidences, drawn from the literature, which were considered as relevant for developing a customer satisfaction framework to offer an integrated framework for the analysis of the organizational processes that lead to the achievement of customer satisfaction that has been used as a working tool about customer satisfaction implementation criteria. Preliminary results of these studies showed that the implementation of a customer satisfaction plan was a major problem even for firms with a good reputation in quality management. Therefore, it was important to identify both these elements which interventions must focus on and the path that must be taken while implementing a customer satisfaction plan. However, identification of the organizational requirements, which vary according to the level of planned achievements, is equally important (Moreno Muffatto, Roberto Panizzolo, 1995). [31]

Eberhard E. Scheuing, Eugene M. Johnson (1989) proposed a model for new service development and focused that competitive pressures were prompting a new found aggressiveness that questions established services offerings and calls for new ways of identifying and satisfying buyers' needs. The study drawn some preliminary conclusions for service management presented as ten propositions viz., service businesses does not use a specialized new service function; the marketing function considered as largely responsible for new services; marketing research techniques find limited use; use of a formal new service development process was limited; most firms use new service evaluation committees; most firms use new service project teams; new service leaders rarely reap personal rewards; profitability was the overriding concerned; competitors were the most powerful source; and the level of new service activity was limited (Eberhard E. Scheuing, Eugene M. Johnson, 1989).[32]

Robert A. Westbrook (1980) empirically examined the suitability of Delighted – Terrible (D – T) measure, for marketing studies of consumer satisfaction / dissatisfaction, through reliability, validity, and measurement properties. Overall, the findings encouraged further use of D – T scale in both basic and applied studies but also alleviate concerns about the quality of satisfaction measurement (Robert A. Westbrook, 1980).[33]

Robert C. Burns et. al., (2003) explored the nature of the relationships between customer service attributes, dimensions of satisfaction viz., facilities, services, information, and recreation experience, and overall satisfaction. The satisfaction-only measures were found to be significantly better indicators than the gap scores of domain-level and overall satisfaction. The items were found to be stronger predictors within the four satisfaction domains than within the overall satisfaction model (Robert C. Burns et. al., 2003).[34]

Lyn Randall, Martin Senior (1994) integrated established research methods into a systematic planning and communication tool that involved customers, management and front-line employees in service quality improvement opportunities. Achieving long-term customer satisfaction necessitates establishing a list of all the problems customers' experience while evaluating the service. For detecting customers' problems, some of the more typical and established methods adopted were complaint analysis; multi-attribute methods; blueprinting; service mapping; and incident-oriented methods. From analysing the customer and employee interviews, attributes in six key categories were identified: viz., admittance; catering; facilities; comfort and security; visitors; and departure. It summarized that quality control and improvement can be effectively achieved only by identifying and monitoring customes'r problems using research methods which should identify quality from the customers' viewpoint and involve the employee in quality analysis, control and improvement (Lyn Randall, Martin Senior, 1994).[35]

Mark Gabbott, et. al. (2000) considered the role of non-verbal communication in consumers' evaluation of service encounters. It provided evidence that the nonverbal communication in a service encounter dramatically impacts on the customer's evaluation of the service event; Second, that this impact was both overall and in relation to specific components, and finally, that there were some differences amongst customer groups in how they react to non-verbal behaviour (Mark Gabbott, et. al. 2000).[36]

Prem N. Shamdasani, JagdishN.Sheth, (1995) demonstrated that experimental role-playing can usefully be employed to examine important strategic and behavioural issues in strategy research. First study had examined the extant literature of interest in the area of strategic alliances specifically, the key predictors of relationship satisfaction and continuity in alliances. Second, study suggested and discussed the appropriate methodology for studying these constructs and their interrelationships followed by discussion on the implications of the findings and the methodology for future research. A total of 221 managers (75 per cent males and 25 per cent females) took part in this study. The results confirmed the importance of commitment, competence and compatibility in ongoing strategic alliances since they strongly influenced alliance satisfaction and continuity. Satisfaction was positively related to continuity since a satisfied firm was more likely to maintain its ongoing relationship than to seek out fora new alliance partner (Prem N. Shamdasani, JagdishN.Sheth, 1995).[37]

L.W. Turley, Ronald P. LeBlanc (1993) conducted exploratory investigation of consumer decision making in the service sector. The findings of the exploratory investigation indicated that the decision matrix for services was different from those associated with either durable or non-durable goods. (L.W. Turley, Ronald P. LeBlanc, 1993).[38]

Gilbert A. Churchill, Jr., Carol Surprenant, (1982) investigated whether it is necessary to include disconfirmation as an intervening variable affecting satisfaction as commonly argued, or whether the effect of disconfirmation was adequately captured by expectation and perceived performance. Because most of the research on consumer satisfaction had used non-durables, this finding had important implications for future research. Finally, the direct performance-satisfaction link accounts for most of the variation in satisfaction (Gilbert A. Churchill, Jr., Carol Surprenant, 1982).[39]

Prashanth U. Nyer (2000) conducted an experiment on real consumers to test what effects complaining may have on changes in the consumers' satisfaction and product evaluations over a one-week period. It was found that consumers who were encouraged to complain reported greater increase in satisfaction and product evaluation compared to consumers who were not explicitly asked to complain. The changes in satisfaction and product evaluations were found to be related to the complaining intensity.

The findings of this study had not suggested that marketers should merely solicit complaints without addressing the causes of the consumers' dissatisfaction. Encouraging consumer complaints may be perceived as fraudulent if the consumers do not receive positive responses from the marketer (Prashanth U. Nyer, 2000).[40]

Sally Venn, David L. Fone, (2005) undertook a study to quantify associations between reported satisfaction with General Practitioner (GP) services and measures of socio-demographic and health status and the effect of adjusting for these factors in comparing satisfaction measured at the level of Primary Care Organisations (PCOs). It suggested that satisfaction varied with age, gender, employment status, marital status, and reported score for Long term limiting illness (LLTI - is recognised as a national measure of self-reported ill-health). The rank order of reported satisfaction for PCOs changed by up to five places after adjusting for these factors. Practical implication of study was comparing measures of satisfaction between organisations to assess relative performance may not be valid unless differences in socio-demographic composition are taken into account (Sally Venn, David L. Fone, 2005).[41]

Antreas Athanassopoulos et. al., (2001) investigated the behavioural consequences of customer satisfaction. More specifically, the study examined the impact of customer satisfaction on customers' behavioural responses. The results supported the notion of direct effects of customer satisfaction on three criterion variables viz., decision to stay with the existing service provider; engagement in word-of-mouth; communications, and intentions to switch service providers (Antreas Athanassopoulos et. al., 2001).[42]

Mark Gabbott, Gillian Hogg (1994) reviewed the literature in the fields of consumer behaviour and the marketing of services in order to examine the main issues facing the consumer in purchasing services, as opposed to goods. Five distinguishing characteristics of services were discussed and the implications of these for the consumers were placed within the information processing model of consumer behaviour theory. The article suggested that there were particular problems for consumers in acquiring effective information regarding services, making comparisons on the basis of that information and subsequently evaluating the service encounter. It investigated the implications for consumer behaviour presented by services as opposed to goods and concluded that services present a number of problems for consumers and suggested that consumers' responses in relation to goods may not be applicable to services. Specifically, that there is a body of knowledge which explains consumer behaviour in relation to goods and that this body of knowledge suggest problems for consumers in choosing and evaluating services (Mark Gabbott, Gillian Hogg, 1994).[43]

Mary C. Gilly, Richard W. Hansen (1985) viewed that effective complaint-handling by an organization can result in such benefits as consumer satisfaction, company brand loyalty, favorable word-of-mouth publicity and decreased litigation. Therefore, organizations should consider the application of strategic marketing concepts when establishing complaint-handling policies. Alternative strategies were proposed and a model for formulating a complaint-handling strategy was described.

A model for formulating a complaint-handling strategy has been described in the belief that by treating complaint-handling as a strategic marketing tool, companies can move from defensive complaint-handling to complaint management. As a result, profits can increase through increased revenues and/or decreased costs (Mary C. Gilly, Richard W. Hansen, 1985).[44]

Debra Grace (2005) conceptualized the notion of Consumer Disposition toward Satisfaction (CDS), defined as the consumer's general tendency to be sufficiently satisfied with the purchase and consumption of the goods and services they utilize. The scale development process was carried out over three stages that is , item generation, scale purification, and scale validation. In departing from the traditional personality trait approach to understanding consumers and their subsequent behaviors, this research adopted an integrated approach which treats consumers as dispositional entities. As such, the CDS scale has the potential to make a considerable contribution in both theoretical and practical terms and, due to its parsimonious nature, may prove to be a valuable diagnostic tool for academicians and marketers in the future (Debra Grace, 2005).[45]

Rolph E. Anderson (1973) considered four psychological theories namely: (1) cognitive dissonance (assimilation), (2) contrast, (3) generalized negativity, and (4) assimilation-contrast for determining the effects of disconfirmed expectations on perceived product performance and consumer satisfaction. The results revealed that too great a gap between high consumer expectations and actual product performance may cause a less favorable evaluation of a product than a somewhat lower level of disparity. The experiment revealed that there was a point beyond which consumer will not accept increasing disparity between product claims and actual performance, at least for certain relatively simple or easily understood products. When this threshold of rejection is reached, consumers will perceive the product less favorably than at a slightly lower level of expectations. More complex products, where there was considerable ambiguity and uncertainty in making judgments, may yield different results as consumers may tend to be more dependent on the information provided to them (Rolph E. Anderson, 1973).[46]

Chiquan Guo et. al. (2004) viewed that although customer satisfaction is one of the fundamental concepts in marketing theory and practices, the direct link between customer satisfaction and a firm's bottom line is still somewhat ambiguous and vague (Chiquan Guo et. al., 2004).[47]

Lai K. Chan, et. al. (2003) reported the development of the Hong Kong Consumer Satisfaction Index (HKCSI), a new type of consumer-oriented economic performance indicator representing the quality of products (commodities and services) sold in Hong Kong as evaluated by Hong Kong consumers as well as the findings of HKCSI from 1998 to 2000, each year with more than 10,000 successful telephone interviews on about 60 products. Its key HKCSI included the direct introduction of consumer characteristics such as age, education, and income in model construction; the wide coverage of services, especially free services; and the adoption of a product weighting system based on Consumer Price Index (CPI), not on Gross Domestic Product (GDP). The results were generally consistent across different products, broadly acceptable and in agreement with previous findings, and were also relevant to Hong Kong's special situation (Lai K. Chan, et. al., 2003).[48]

Sylvie Naar-King et. al. (2002) evaluated satisfaction of a parent, child, and staff with a collaborative, interdisciplinary program for children with special health care needs. More than 80 per cent of parents were satisfied with care and felt that the time involved was worthwhile, but access did not meet criterion. Child satisfaction approached but did not meet criterion. Targets for improving the program and future evaluation efforts are discussed. Results provided support for integrating health and mental health care services for children with special needs (Sylvie Naar-King et. al., 2002).[49]

Elisabeth Lundberg et. al. (2000) examined the effects of customer familiarity that is the number of previous consumption-related experiences on expectations prior to the consumption of a service; performance perceptions after the consumption. It suggested that customer familiarity affects post-purchase assessments in terms of performance perceptions and satisfaction. Its key finding was that familiarity was negatively associated with performance perceptions and satisfaction (Elisabeth Lundberg et.al. 2000).[50]

Gail Scott (2001) explored the ways to make that customer service excellence a dream a reality. Through this article the 'six strategies for success' was suggested considered to be the foundation for a system wide service effort to create and sustain a culture of continuous improvement. These six strategies of success included, raise awareness in the organization; set service expectations and standard of behaviour; identify and eliminate barriers and obstacles; learn and develop skills; listen to your customers as well as reinforce and support continuous improvement (Gail Scott, 2001).[51]

Rade B. Vukmir (2006) presented an analysis of the literature examining objective information concerning the subject of customer service, as it applieed to the medical practice. Its findings suggested that there was a significant lack of objective data correlating customer service objectives, patient satisfaction and quality of care. Patients presented predominantly for the convenience of emergency department care. Specifics of satisfaction were directed to the timing, and amount of caring.

Demographic correlates including symptom presentation, practice style, location and physician issues that had directly impact on satisfaction. It was most helpful to develop a productive plan for the difficult patient, emphasizing communication and empathy. Profiling of the customer satisfaction experience was best accomplished by examining the specifics of satisfaction, nature of the Emergency Department (ED) patient, demographic profile, symptom presentation and physician interventions emphasizing communication– especially with the difficult patient (Rade B. Vukmir, 2006).[52]

Yoshio Kondo (2001) viewed customer satisfaction as the final target of total quality management, and many attempts that have been made for its measurement. At the same time, it should be noted that there are always plural kinds of customers viewing quality from different perspectives and that the expression of no customer dissatisfaction not necessarily equal to customer satisfaction. Of the two kinds of quality, must be quality and attractive quality, the latter usually considered as more important for satisfying customers. The hypothesis-testing approach was effective in the market survey of attractive quality. Attractive quality was of subjective character, and it easily tends to become surplus. However, it was important to note that the quality that tends to appear excessive to the manufacturer but was strongly demanded by the customer can be the key to superior new technology and excellent quality products. So, they should be regarded not as surplus quality but as an attractive quality. Employee satisfaction of intrinsic and spiritual character is the source of excellent quality and customer satisfaction, and leaders and managers should respond positively and encourage the employees' opinions (Yoshio Kondo, 2001).[53]

Syed Saad Andaleebm, Carolyn Conway (2006) conducted study in which secondary research and qualitative interviews were used to build the model of customer satisfaction. The regression model suggested that customer satisfaction was influenced most by responsiveness of the frontline employees, followed by price and food quality (in that order). Physical design and appearance of the restaurant did not have a significant effect. A research implication was that to explain customer satisfaction better, it may be important to look at additional factors or seek better measures of the constructs. Practical implications of the study was that full service restaurants should focus on three elements service quality (responsiveness), price, and food quality (reliability). If customer satisfaction was to be treated as a strategic variable (Syed Saad Andaleebm, Carolyn Conway, 2006).[54]

Kathleen Seiders et. al. (2005) proposed that the relationship between satisfaction and repurchase behavior was moderated by customer, relational, and marketplace characteristics. They further hypothesized that the moderating effects emerge if repurchase is measured as objective behavior but not if it was measured as repurchase intentions. To test for systematic differences in effects, the authors estimated identical models using both longitudinal repurchase measures and survey measures as the dependent variable.

The results suggested that the relationship between customer satisfaction and repurchase behavior was contingent on the moderating effects of convenience, competitive intensity, customer involvement, and household income. As the authors predicted, the results were significantly different for self-reported repurchase intentions and objective repurchase behavior. The conceptual framework and empirical findings reinforced the importance of moderating influences and offer new insights that enhance the understanding of what drives repurchase behavior (Kathleen Seiders et. al., 2005). [55]

3.2 REVIEW OF LITERATURE ON PATIENTS' SATISFACTION:

A brief outline of literature on patients' satisfaction has been given as follows.

In the healthcare industry, hospitals provide similar kind of service, but they do not provide the same quality of service. Furthermore, consumers today are more aware of alternatives offerings and rising standards of service have increased their expectations. Measurement of patients' satisfaction with services provided by the concerned hospital is therefore, important as the patients constitute the hospital's direct business. The effectiveness of the hospital relates to provision of good patient care as intended. The patient satisfaction is the real testimony to the efficiency of hospital in to providing hospital services. As the hospital service can also be considered as similar to other service sectors, the same criteria can be applied for determining the patients' satisfaction based on the quality of services provided by hospitals.

The review of literature on patients' satisfaction has been classified as follows.

(1) Patients' Satisfaction with Quality of Services (2) Patients' Satisfaction (3) Comparison of Patients' Satisfaction from Hospitals (4) Patients' Satisfaction and Customer Relationship Management (5) Measurement of Attitude of Patients (6) Patients' Expectations/Perceptions (7) Patients' Safety (8) Work Motivation for Hospital Employees (9) Patients' Care Development Programme. (The summary of the literature on Patient satisfaction is given in Appendix XI to Appendix XX).

3.2.1 Patients' Satisfaction with Quality of Services:

A model of service quality was developed through an exploratory research by Parasuraman, Zeithaml, and Berry (1985), in four services categories, such as, retail banking, credit card, securities brokerage, and product repair and maintenance, conducted with the help of total 12 focus group interviews. It revealed that the criteria used by consumers in assessing service quality fit in potentially overlapping dimensions. These dimensions were reliability, responsiveness, competence, access, courtesy, communication, credibility, security, understanding/knowing the customer, and tangibles (A. Parasuraman, Valarie A.Zeithaml, and Leonard L. Berry, 1985).[56]

An another study by them focused on conceptualization and operationalisation of the service quality construct that described the development of 22 items instrument called as SERVQUAL used for assessing customers' perceptions of service quality in service and retailing organisations. The original 10 dimensions of service quality measurement were combined in to five distinct dimensions called tangibles, reliability, responsiveness, assurance, and empathy. The assurance dimensions contains five original items of earlier study of Parasuraman, Zeithaml, and Berry (1985) viz., communication, credibility, security, competence, courtesy, as well as empathy dimension. Empathy dimension contained two original items of the same study as first understanding/knowing customers and access. Therefore, while SERVQUAL has only five distinct dimensions, they captured facets of all 10 originally conceptualized dimensions (A. Parasuraman, Valarie A.Zeithaml, and Leonard L. Berry, 1988).[57]

Parasuraman Zeithaml, and Berry (1991) also undertook a follow up study to redefine the SERVQUAL. In this study, the customer assessments of service quality were measured for three types of services viz., telephone repair; retail banking, and insurance). In the original study of 1988, the SERVQUAL was considered as generic instrument with good reliability, validity and broad applicability even after this study they continued to feel confident of usefulness of SERVQUAL (A. Parasuraman, Valarie A.Zeithaml, and Leonard L. Berry, 1991).[58]

De Dennis McBride et.al. (2002/2003) conducted survey of consumers and visitors at Western State Hospital (WSH), Washington to gain their perspective on the quality of care, services, and hospital environment. Their major findings suggested that, consumers and visitors at WSH were generally satisfied with their hospital experience. (De Dennis McBride, Jonathan Lindsay and Morgan Wear, 2002/2003).[59]

Pauy Cheng Lim and Nelson K.H. Tang (2000) conducted study at Singapore hospitals to determine the expectations and perceptions of patients. They considered total six dimensions and an analysis covering 252 patients revealed that there was an overall service quality gap between patients' expectations and perceptions, thus, improvements were required across all the six dimensions. It became clear that assurance and responsiveness were the critical dimensions of Singapore hospitals' service quality. However, it was found that services, as perceived by the patients failed to meet expectations in all the six dimensions (Pauy Cheng Lim 7 Nelson K.H. Tang, 2000).[60]

Mik Wisniewski and hazel Wisniewski (2005) undertook study at the Scottish Colposcopy Clinic between October 2000 and 2001 aimed to measure service quality using both the gap concept and service quality dimensions using SERVQUAL instrument developed by Parsuraman et. al., (1985) that was modified by Anderson and Zwelling (1996). Their findings revealed that largest service quality gap was observed for the reliability of services and the need for improved premises (Mik Wisniewski and hazel Wisniewski, 2005).[61]

Anne E. Tomes and Stephen Chee Peng Ng (1995) carried out study in the medical wards of a NHS large general hospital in the East of England over a period of three months in 1993, to develop a measurement scale to assess the quality of service provided in NHS and NHS trust hospitals and to identify the basic constructs underlying patients perceptions of quality of service provided by these hospitals. The two questionnaires were piloted on 20 patients. The final questionnaire were prepared consisting of 49 statements and major 8 dimensions emerged, in which six dimensions were relating to Intangibles viz., empathy/understanding, relationship of mutual trust, commutations, reliability courtesy and dignity and two related to tangibles viz., food, and physical environment.

The study also identified seven factors relating to the service quality with respect to in-patient care five Intangible factors that is empathy, relationship, of mutual respect, dignity, understanding, religious needs and two tangible factors- food and physical environment (Anne E. Tomes and Stephen Chee Peng Ng, 1995).[62]

Ambuj Bharadwaj (et. al.2001) conducted study to assess the spectrum of expectations people had from health care services and the variation in their expectations among different demographic and socio economic strata. It further aimed at studying the marketing orientation of a selected private hospitals located at Delhi and the consumer's perspective of perceiving the quality of health care delivered in terms of the satisfaction/ dissatisfaction with different attributes of the service delivered and such attributes were Quality of accessibility/tangibles and facilities; interpersonal relationship; technical care; continuity of services, and administrative services. An exploratory study was conducted by contacting 80 patients and the findings revealed that the reason for choice of hospital follow the preference in the order own choice due hospital's image; suggested by friends and relatives of the patient, and referred by their family physician. Further, patients had selected this hospital as per the perceived image and various other attributes which includes highly qualified doctors; advanced investigation facilities; large hospital cleanliness; courteous behavior of the hospital staff, and easy accessibility. The crux of this study was that in order to be successful in today's competitive health care environment, the health care provider should deliver the services tailored to consumer needs and must actively review the changes in their demands and expectations in context to time and the socioeconomic strata of the community being served (Ambuj Bharadwa, et. al.2001).[63]

David Camilleri, Mark O'Callaghan (1998) applied the SERVQUAL model and also used Donabedian's framework to compare and contrast Malta's public and private hospital care service quality, through the identification of six dimensions such as catering; hospital environment; professional and technical quality; patient amenities; service personalization, and accessibility, which includeed 16 service quality indicators and the use of a Likert-type scale, Two questionnaires were developed to measure patients' pre-admission expectations for public and private hospital service quality. It also measured patients' perceptions of provided service quality and their results showed that both private and public hospital service users considered the professional and technical care quality as well as the degree of personal attention given to them as the two most important aspects of the service product. Private sector users considered price as that factor having least importance, On the other hand, public service users considered price as second only to the quality of core services. The study also showed that private hospitals were expected to offer a higher quality service, particularly in the hotel services, but it was the public sector that was exceeding its patients' expectations by the wider margin (David Camilleri, Mark O'Callaghan, 1998).[64]

Joseph C.H. Wong (2002) undertook a project to evaluate quality of service provided for ambulatory clients at the Bone Densitometry Unit in the Royal Brisbane (Austria) Hospital using the SERVQUAL dimensions of service quality viz., tangibles, reliability, responsiveness, assurance and empathy. Total number of 102 patients out of 140 completed the 12 items covering five dimensions during the six-month period. The findings showed high satisfaction ratings with both perception scores and expectation-minus-perception gap scores. Of the five dimensions, responsiveness, assurance and empathy factors were more important predictors of overall service satisfaction (Joseph C. H. Wong, 2002).[65]

Christopher Johns and Stephen Bell (1995) of UK with the assistance of the clinical audit and quality facilitator attempted to discover the reasons why the day hospital was ineffective. The main findings highlighted some issues such as there was no policy for referral of patients or policy in use was ineffective; patients were not regularly reviewed; 50 per cent of patients attending the day hospital were there for purely social reasons. The medical audit facilitator met with the charge nurse of the day hospital and together they designed a questionnaire that was completed by the nursing staff on all 68 patients attending the day hospital. The main change implemented as suggested by the audit facilitator and charge nurse, a result of the findings included that quality team need to be established to look at all aspects of the day hospital; admission criteria are to be designed for selection of patients for admission (Christopher Johns and Stephen Bell, 1995).[66]

Yves Eggli, Patricia Halfon (2003) viewed that most of the conceptual frameworks used for hospital quality management exhibit shortcomings, terminology barriers or too much complexity, and proposed a simple model specific to hospitals based on four entities viz., Patients; activities; resources, and effects, and six levels viz., representations; priorities; measures; standards; evaluation, and accountability, which can be plotted against the four entities in order to measure the development of quality (Yves Eggli, Patricia Halfon, 2003).[67]

James Agarwal, (1992) examined the usefulness of the SERVQUAL scale for assessing patients' perceptions of service quality in a mid-sized hospital in the Southern part of the United States using 5-point Likert scale with 15 statements relating to patients' expectations on the quality of the service that hospitals should offer and 15 corresponding items relating to their perceptions of the quality of service actually delivered. The scale was tested on fundamental principles such as reliability; underlying dimensionality; and convergent; discriminant, and nomological validity. Items for each subscale that is, tangibles; reliability; responsiveness; assurance, and empathy were subjected to reliability assessment. It was concluded that practical insights such as recognition and reward system will improve an employee's attitude on the responsiveness dimension of service quality. The scale provided hospital administrators a tool for identifying low scores on any of the dimensions, which could, however, be symptomatic of a deeper problem (James Agarwal, 1992).[68]

Cem Canel, Elizabeth A. Anderson Fletcher, (2001) analyzed the quality of service provided by a university Health Care Center at the University of North Carolina at Wilmington's (UNCW) Students' Health Center. Students' expectations and perceptions of the centers services were identified and another survey was also administered on the employees of the Center to compare student's perceptions to those of the employees. The SERVQUAL instrument, as modified for health care by Mangold and Babakus (1991), was administered to 500 UNCW students and all 14 employees of health center. As per the findings, the employees felt that students valued the dimension of reliability most of all and followed by assurance, empathy, responsiveness and tangibles. The students' responses supported the findings of Parsuraman et. al. (1985) and the order of service quality determinants viz., reliability; responsiveness; assurance; empathy, and tangibles. Both groups listed reliability as the most important determinant and tangibles as the least important determinant of service quality in a University Health Care Center. The most important outcome of this study was the linking of students' perception of service quality to resource allocation decisions (Cem Canel, Elizabeth A. Anderson Fletcher, 2001).[69]

Mahmoud M. Yasin, Jafar Alavi (1999) conducted study in order to illustrate how the Constant Market Share (CMS) Model can be utilized to show the competitive benefits of TQM. They used fictitious data for the period of 1988-1990 for patients' admittance to the three hypothetical hospitals A, B, and C operating in a Metropolitan Area where hospital A was the largest and B was the second largest, and C was the smallest. Several hospital administrators were interviewed and consulted during the data generation process to ensure as much realism in the data as was possible. They assumed that hospital implemented TQM on all of its operational units. Hospital B, however, did not take any quality initiatives. Hospital C implemented TQM only in its cardiac unit. The results clearly showed that hospital A benefited the most in terms of patient admissions during this period, hospital B was very disappointing, but not surprising since this hospital did not apply TQM in any of its units, and Hospital C performance was better than hospital B. Based on the results of this study, it was concluded that the fears of some healthcare administrators are unfounded. Not only that TQM does not compromise organizational effectiveness, but it actually improves it, as it contributes to increasing market share (Mahmoud M. Yasin, Jafar Alavi, (1999).[70]

Clare Chow-Chua, Mark Goh (2002) presented a research paper on knowledge-based framework for evaluating the performance of a hospital using a model based on the Singapore Quality Award (SQA) criteria and the Balanced Score Card (BSC) approach. A specific case study of a public sector hospital in Singapore was used to illustrate how the SQA and the BSC can be integrated to help a public sector hospital to implement and manage performance-based programs. The preliminary results suggested that hospitals can also use this approach to their advantage, yielding sustainable improvement in patients' satisfaction and better inter-departmental communication.

Through this framework, hospitals can make better quality decisions based on structured measurement and knowledge (Clare Chow-Chua, Mark Goh, 2002).[71]

C. Potter, P. Morgan and A. Thompson, (1994) initiated research project with the help of by Cardiff Business School for National Health Service (NHS) in Wales, U.K., to investigate how an approach to continuous quality management might be facilitated in a hospital setting. Three departments were selected for consideration, because of their service orientation to the rest of the unit that included medical records; operating theatres; and X-ray. Its results aroused out of staff brainstorming sessions and an observation, concerning ways to improve the quality of service to patients included important aspects. Patients appeared quite well and found as satisfied with the service received as far as courtesy and consideration was concerned. Medical records staff should, therefore, be encouraged to continue to pursue their work in the professional manner in which they were performing. Informally or formally to maintain and enhance the service and the gains, feedback from patients should continue to be encouraged. Some explanation for the delays (waiting time) should be given, so that patients should be aware about delays. If patients were unable to see the doctor of their choice some explanation should be given to patient (C. Potter, P. Morgan and A. Thompson, 1994).[72]

Judith H. Hibbard, Jean Stockard, and Martin Tusler, (2005) conducted study to assess the long-term impact of a public hospital performance report on both consumers and hospitals. In the study the Alliance, a large employer purchasing cooperative in Madison, Wisconsin, sponsored the public report on hospital quality and safety. The report, Quality Counts, compared performance on twenty-four hospitals in South Central Wisconsin. The experimental design included two intervention groups and one control group. The primary intervention group was the twenty-four hospitals in South Central Wisconsin and the other ninety-eight general hospitals in Wisconsin were randomly assigned to either the secondary intervention or the control group. The findings provided substantial evidence that making performance information public stimulates long-term improvements beyond those stimulated by private reports. The improvements appeared to be linked to quality improvement efforts that began immediately after the report's release. Its findings suggested that the mechanism by which public reporting affects improvement was more likely to be with concerns about reputation than with concerns about market share (Judith H. Hibbard, Jean Stockard, and Martin Tusler, 2005).[73]

Kathleen L. McFadden (1996) analysed the proposed policy changes in patient care, along with a total restructuring plan of a hospital's obstetrics ward, aimed at to improve overall operational efficiency. The study was conducted, in conjunction with a large Texas hospital, USA, in its maternity section as it was the largest revenue generating area of this hospital, with the intent of the proposed changes in patient flow is to improve quality of service and operating efficiency.

The hospital under study altered the existing health care facility by constructing 15 Labour; delivery, and recovery (LDR) room suites, and incorporated the proposed policy changes in patient movement. These modifications increased overall operating efficiency and patient satisfaction. The hospital had also seen a reduction in average length of stay. It demonstrated how quantitative models can be used to evaluate the cost-effectiveness of hospital programmes. Based on this study, the application of operations management techniques proved useful in improving decision making with regard to the hospital's alternatives (Kathleen L. McFadden, 1996).[74]

Raduan Che Rose, Mohani Abdul, and Kim Looi Ng, (2004) considered six quality dimensions viz., technical, interpersonal, amenities/environment, access/waiting time, costs, outcomes and religious needs identified from the literature. This study provided a more holistic comprehension of hospital service quality prediction. In total, 491 usable questionnaires were collected on the spot that is 247 from the public hospitals and 244 from the private hospitals in Malaysia. Its findings suggested that the technical quality factor was the most important determinant of service quality for the two hospitals. Although, 79 percent of variation was explained, other than technical quality the impact of the remaining factors on quality perception was far from constant and socio-economic variables further complicated unpredictability. Contrary to established beliefs, the cost factor was found to be insignificant. Hence, to manage service quality effectively, the test lies in how well healthcare providers know the customers they serve. It is not only crucial in a globalized environment, where trans-national patients' mobility is increasingly the norm, but also within homogeneous societies that appears to converge culturally (Raduan Che Rose, Mohani Abdul, and Kim Looi Ng, 2004).[75]

Eitan Naveh, Zvi Stern (2005) conducted study at the hospital level by including all acute care hospitals in Israel and data was collected from 16 of the country's 23 hospitals., It compared hospital performance before and after implementation of the Quality Improvement (QI) program. It aimed to brought an empirical evidence to support the hypothesis that a QI program in a general hospital, a special context of the health care delivery system did not necessarily lead to better overall organizational performance results. Its findings showed that QI created meaningful improvement events. In addition, the research supported the hypothesis that increasing the number of QI activities (items) included in the QI program brought about more improvement events. The results did not supported the hypothesis that high, rather than low, intensive implementation of QI activities leads to more improvement events (Eitan Naveh, Zvi Stern, 2005).[76]

Mike Hart (1995) undertook a pilot study, the aims of which were to determine a baseline for waiting times and to establish a sound methodological base for further measurement work. The study actually used three different methods to calculate an average waiting time viz., time between appointment time and the start of the consultation, time between arrival time and the start of the Consultation, and waiting time estimated periodically throughout the clinic. The data were collected by nursing staff for each patient in the clinic. Its findings suggested that patients will differs in their approach to waiting times depending on their domestic, work and other commitments. Most patients would like a degree of predictability in the time spent in an out-patient department so that other commitments related to work; child-care arrangements and so on can be coordinated (Mike Hart, 1995).[77]

Mike Hart (1996) presented the results of a monitoring programme instituted to comply with the objectives laid down in The Patients' Charter (U.K.) aimed to assess the quality of out-patient clinics by the use of single, simplistic indicators such as a waiting time. It examined the ways in which total quality management was deployed in a health-service context and also to incorporate more user-centered approaches into evaluations of quality in the National Health Service, such as the patient satisfaction survey based on the application of the SERVQUAL. It concluded that the import of TQM philosophies and techniques into the National Health Service (NHS) cannot be an easy process. (Mike Hart, 1996).[78]

David M. Williams and Janet M. Williams, (1994) worked on the project which identified patients' problem areas viz., waiting times in clinic; availability of case notes; clinic management; medical records; and patient information. The Project's achievements had made real changes to the quality of the out-patient service viz., queues at the Out-patient department desk have been eliminated; number of patients waiting less than 30 minutes has increased; number of out-patients' clinics starting on time has increased; case note availability has now reached 99.9 per cent at the start of each clinic; all patients have individual appointment times; an out-patient information booklet has been produced; and doctors received monthly feedback in league table format of their clinic start-time records and the average wait of patients in their clinics (David M. Williams and Janet M. Williams, 1994).[79]

Keith Stevenson et. al., (2004) conducted the project to test a method for involving patients in setting quality indicators locally for their primary care providers. The study was carried out at East Lindsey Primary Care Group (PCG) during May 2001 to October 2002. A sample of 92 UK patients voluntarily participated in focus groups that discussed about elements important of local primary care provision to them. While the creation of the patient generated quality indicators was one aim of the study another was to gain practices' acceptance of the indicators so that they would assess themselves against them and carry out changes to their service provision to better meet the needs of patients. The patient generated quality service indicators included 18 indicators and based on five dimensions viz., accessibility; consultation; referral; prescriptions, and communication (Keith Stevenson et. al., 2004).[80]

James Agarwal, (1992) undertook a study to develop multiple risk-adjusted measures of hospital outcomes using available data sources and then to determine whether or not these measures were correlated. However, rather than adopting positive outcome indicators, they considered adverse events, namely inpatient mortality indices (Risk-Adjusted Mortality Idex- RAMI), unscheduled readmissions (Risk- Adjusted Readmission Index- RARI), and complications (Risk- Adjusted Complication Index- RACI). The rationale in doing so was the ready availability of data from hospital abstract and billing information. The relationship among the three indices was tested by using a Spearman rank-order correlation, which revealed that no relationship between a hospital's rankings on any of these indices. The hospitals high on one index were not necessarily high on either of the other two measures. It was concluded by commenting that the three indices should not be combined into a uni-dimensional measure of quality, at least at the hospital level of analysis (James Agarwal, 1992).[81]

Ronald L. Zailocco, (1992) conducted a national telephone survey amongst the Voluntary Hospitals of America of 20,000 household heads in 40 separate markets representing 20 States, during 1984 to 1988. Respondents were asked to rate local hospitals, identified by name, in comparison with other area hospitals. Ratings were analyzed against 16 variables from four general areas viz., community; institutional; quality and cost, and control. It found that consumers believed that they can differentiate between high and low quality hospitals and were willing to pay more for higher quality hospitals. Patients' relations; medical staff; nursing staff; convenience, and technology were identified as factors defining a level of quality. Hospitals rating highest in quality had the characteristics viz., nonrural larger; tertiary care;, teaching, higher patient census, better staffed; lower mortality rates; higher average employee salaries, and more costly (Ronald L. Zailocco, 1992).[82]

E. Joseph Torres, Kristina L. Guo (2004) described several approaches for implementing quality improvement initiatives to improve patients' satisfaction, which enabled health-care organizations to position themselves for success. (E. Joseph Torres, Kristina L. Guo, 2004).[83]

Christine Lapointe, Jan Watson, (2004) reported that while making educational presentations, the refractive laser companies found question related with Clinical and surgical staff, that is, how to modify everything from record-keeping to payment to patient flow to satisfy' patient-customer expectation, and made several recommendations. It included areas which the refractive surgery staff had to learn and restructure in their practice, which included take a time for preparation and organisation to anticipate any possible patient situation; proper communication standardized forms so that all patients and staff are getting and giving required information; accountability and commitment for all staff members; use efficiency and foresight for the surgery; and serventhood must be the primary driver which ensure excellent care of patient (Christine Lapointe, Jan Watson, 2004).[84]

C. Jeanne Hill, et. al., (1989) conducted study to examine the importance of nineteen selected criteria consumer might use in their choice of a professional service provider. Factor analysis reduced the variables to five factors which included knowledge; comfort; time, social reputation, and accessibility. The result presented strong implications for competitiveness of professional service providers, with knowledge and comfort items representing as the most important to individuals (C. Jeanne Hill, et. al.1989).[85]

James H. McAlexander et. al. (1994) examined the efficacy of four models for measuring service quality and concluded that SERVPERF methods were superior to SERVQUAL methods. Their study found that dental patients' assessments of overall service quality were strongly influenced by assessments of provider performance. Furthermore, an examination into the causal order between perceptions of overall service quality and patients' satisfaction revealed such strong reciprocal influences that it's impossible to conclude that one empirically precedes the other. Finally, the study also found that purchase intentions are influenced by both patients' satisfaction and patients' assessments of overall service quality (James H. McAlexander et. al. 1994).[86]

Stephen J. O'Connor, et. al., (1994) conducted study that included the entire medical staff (81), administrative staff (51), patient-contact (non physician) employees (382), and established adult patients (2,069) which showed that doctors in a multispecialty clinic rated patient expectations of reliability;, responsiveness; assurance, and empathy lower than did administrators, patient-contact personnel, and, most significantly, the patients themselves. Health care marketers need to educate doctors on the importance patients place on certain issues and how to address them. (Stephen J. O'Connor, et. al.1994).[87]

Katherine McKinnon, Paul D. et. al., (1998) undertook study in which the patients were asked to comment and to evaluate how satisfied they were and some of the aspects of outpatient which showed that high levels of patients' satisfaction with the quality of their consultations and the attitude shown to them by medical staff. Patients' feedback showed that despite the introduction of the Patients' Charter, waiting times from referral to appointment, and delays in clinics were the main areas for improvement. Its findings showed that patients were, however, remarkably tolerant and understood the pressures and demands placed upon outpatient staff (Katherine McKinnon, Paul D. et. al., 1998).[88]

Kui-Son Choi, Hanjoon Lee et. al. (2005) conducted study to investigate the structural relationships between out-patient satisfaction and service quality dimensions and an examination of the estimated path coefficients showed that the pattern of relationships between service quality and patient satisfaction was similar across the gender, age, and service type subgroups. Its results also revealed that the level of satisfaction, was not the same for subgroups when divided by age and the types of services received (Kui-Son Choi, Hanjoon Lee et. al., 2005).[89]

Fenghueih Huarng, Mong Hou Lee, (1996) explained about use of a computer simulation model that was developed to show how changes in the appointment system, staffing policies and service units affected the observed bottleneck. Its results showed that the waiting time was greatly reduced and the workload of the doctor was also reduced to a reasonable rate in the overwork and overcrowding periods (Fenghueih Huarng, Mong Hou Lee, 1996).[90]

Fiona Payne, (2000) provided information about how out-of-hours services were used by those with mental health problems. It highlighted some clear patterns in how out-of-hours services were used for mental health problems. It was useful in helping providers to plan their services more appropriately. The study also brought some of the problems in collecting routine data of this nature (Fiona Payne, 2000).[91]

David Sinreich, Yariv Marmor (2005) recognized that in order to provide quality treatment to all the patient types, Emergency Department (ED) process operations have to be flexible and efficient. They examined one major benchmark for measuring service quality, patient turnaround time. The analysis revealed that waiting time comprises 51-63 per cent of total patient turnaround time in the ED and its major components included, time away for an x-ray examination, waiting time for the first physician's examination, and waiting time for blood work (David Sinreich, Yariv Marmor, 2005).[92]

Anthony J. Avery et. al., (1996) addressed some issues concerning the use of general practice and Accident and Emergency (A & E) services outside normal surgery hours. They found marked differences in the distribution of problems that patients presented to the two types of service that is General Practices and Accident and Emergency services. (Anthony J. Avery et. al. 1999).[93]

3.2.2 Research Studies Relating to Patients' Satisfaction:

Robert Rosenheck et. al., (1997) undertook study to examine patient and facility related determinants of satisfaction with inpatient mental health services. It concluded that the strongest and most consistent predictors of satisfaction were older age and better self reported health. Patients' characteristics associated for more of the variance in satisfaction than did facility characteristics. Older and healthier patients reported greater satisfaction with mental health care services (Robert Rossenbeck , Nancy J. Wilson,and Mark Meterko, 1997).[94]

R.D. Sharma and Hardeep Chahal, (2000) conducted a research study to understand the extent of patient satisfaction with diagnostic services. The study was conducted in 3 reputed hospitals of Jammu city during April 1996 to March 1997, with 81 statements questionnaire having five point scale, and data were collected from pre-tested questionnaire, and finally analyzed responses of 220 patients.

The study has constructed special instrument for measurement of patients' satisfaction and captured information from patients about behaviour of doctors; behaviour of Paramedical staff; quality of administration, and atmospherics / environment of hospital and also considers role of patients' demographic characteristics like gender, occupation, education and income. Their results of pretesting of questionnaire were found satisfactory. The results revealed that in choosing a hospital patients gave first preference to the efficiency of doctors followed by prior-family experience, and recommendations of friends and relatives. The findings identified several non-medical aspects of some of the service encounteres that were responsible for producing increased satisfaction, and major items included knowledge; cooperation; interpersonal warmth; adequate and timely information; prompt services; efficiency of the staff, and convenience etc. Professional ability was ranked amongst the top three factors influencing overall patients' satisfaction with regard to doctors and medical and paramedical staff (R.D. Sharma and Hardeep Chahal, 1999).[95]

Prasanta Mahapatra, Srilatba S. Sridbar P. (2001) conducted a survey in 25 District or Area Hospitals managed by the Andhra Pradesh Vaidya Vidbana Parishad (APVVP) during May to July 1999 from 1179 persons, and found that overall level of patients' satisfaction was about 65 per cent. The patients' assessment of hospital services showed the major dimensions viz., access-availability-convenience; communication; financial aspect; general satisfaction; interpersonal aspects; technical quality; and time spent with doctor. Corruption appeared to be very highly prevalent and was the top cause of dissatisfaction among selected patients. Other important areas of hospital services contributing to patients' dissatisfaction were poor utilities like water supply, fans, lights etc., and poor maintenance of toilets and lack of cleanliness, and poor interpersonal or communication skills (Prasanta Mahapatra, Srilatba S. Sridbar P., 2001).[96]

Talluru Sreenivas, G.Prasad (2003) carried out an empirical study to find out an answer to the question as to how far the high technology hospitals had attained their organisational goals. The study evaluated patients' satisfaction as a vital tool to measure efficiency of three large hospitals, at Hyderabad city managed by Government viz., Osmania General Hospital 240 patients, Quasi Government (Nizam's Institute of Medical Sciences 240 patients), and Corporate Sectors (Deccan Hospitals Corporation Limited – 90 patients), who are providing tertiary care and are considered as high-tech hospitals. Patients' need services considered the only reason for a hospital's existence, which are reasonably accessible and readily available at all times. It was concluded that out of three sample hospitals, Deccan that runs along corporate lines was satisfying the needs of the patients considerably.

Though, it stood first in the analysis, these hospitals were not away from the problems such as, Doctors are unable to come out from their own psychological set up; Paramedical staff is becoming strong and envious of doctors and Institution and unable to come up to the expectations of the top administration; cost of medical care (Talluru Sreenivas, G.Prasad, 2003).[97]

Arpita Bhattacharya et. al. (2003) evaluated the perception of Patients and found that Very high levels of satisfaction were expressed on doctors' work. The technical aspects of nursing care were satisfactory to 88 per cent of patients. Moderate levels of satisfaction were recorded regarding the general attitude of nurses and ward servants. 37 percent of patients felt the treatment facilities could be better (Arpita Bhattacharya et. al., 2003).[98]

Sharon E. Riley et. al. (2005) assessed parent satisfaction with children's mental health services with instrument called the "Youth Services Survey for Families (YSSF)". Its results interpreted as providing support for the reliability of the YSSF in evaluating children's mental health services in Community Mental Health Centers (CMHCs) (Sharon E. Riley et. al. 2005).[99]

Venkatapparao Mummalaneni et. al. (1995) empirically investigated, by obtaining total 2,340 responses, two proposed models of patients' satisfaction the Mediational model and the Moderator model. In the Mediational model, sociodemographic characteristics such as sex; age; employment status; occupation; education, and income were viewed as mediators in the relationship between healthcare attributes and patients' satisfaction, and in Moderator model patients' satisfaction was influenced by both characteristics of the delivery system and patient sociodemographics. Six major dimensions of satisfaction were considered viz., access; financial aspects; availability of resources; continuity of care; technical quality, and the interpersonal manner of the physician. The results indicated that a huge proportion of the variance in consumer satisfaction was accounted for by the delivery system characteristics. Income was the only sociodemographic variable that appeared to have much influence on satisfaction, but it would have relevance only if providers were targeting a specific income group (Venkatapparao Mummalaneni, 1995).[100]

D. Andrew Loblawa et. al. (2004) conducted study and respondents completed two questionnaire (t1 & t2) packages. The first package (t1) was completed in the clinic and also included demographic information on age; gender; education; marital status; primary cancer site, and whether the patient had immigrated to Canada. Patients were instructed to complete the second package at home between 3 to 5 days later and to return it by mail. Of the 149 eligible patients we approached, 92 (62 per cent) agreed to participate and 80 (87 per cent) outpatients at a Canadian Cancer Center provided data at both t1 and t2.

Exploratory factor analysis extracted two factors, labeled 'physician disengagement' and 'perceived support,' with average coefficient alpha values of 0.93 and 0.90. Test–retest reliability was 0.83 and 0.73, respectively, for the two factors. The two (t1 & t2) questionnaire was a brief, valid and reliable questionnaire that taps two complementary facets of patient satisfaction (D. Andrew Loblawa et. al., 2004). [101]

Iris Gourdji et. al. (2003) examined the patients' satisfaction and importance of ratings of quality in an outpatient oncology center by collecting data from a convenience sample of 96 patients from an oncology outpatient center completed a 26-item patients' satisfaction questionnaire (SEQUS). Overall satisfaction ratings indicated that patients were satisfied with their care. Patients' perception of waiting time and lack of questioning regarding their medications by the pharmacist were identified as two areas needing improvement. Their findings suggested that by identifying what was most important to patients, nurses can readily modify the care environment to enhance patients' satisfaction and quality of care. The patients indicated three areas that were rated by them as low in satisfaction and high in importance which included cleanliness of the washrooms in the waiting area; limited pharmacist inquiry into patient; medication regimen, and length of waiting time (Iris Gourdji et. al., 2003). [102]

Rob Baltussen, and Yazoume Ye (2006) compared perceived quality of care of 853 pairs of Users and Non-Users of modern health services with an aim to Nonusers were matched to users on age, sex, occupation of the head of the household and distance to health post. Questions were structured according to four dimensions of quality of care. Its findings suggested that both users and non-users were relatively favourable about health personnel practices and conduct (77 Per cent versus 70 Per cent of the maximum attainable score), and about health care delivery (77 Per cent versus 74 Per cent). The conclusion of the study was that in order to remove barriers to increase utilization, policy makers may do good to target their attention to improve financial accessibility of modern health services and improve drugs availability. These factors seemed most persistent in decisions of ill people to stay with home-based care and/or traditional medicine, or go to consult modern health services (Rob Baltussen, and Yazoume Ye, 2006). [103]

Martha T. Ramirez Valdivia et. al. (1997) proposed alternatives to achieve the timeliness customer service standard for United States Veterans', and thus try to enhance the hospital's efficiency by improving the quality of its services. The research study presented a new methodology, called as the Simulation Service Quality System (SSQS), developed in order to improve operating performance measures in the light of customer preferences. The results suggested that in order to reduce the waiting time to be seen by a doctor, it was necessary to reduce the check-in time window. For this, it was necessary that the clinic's administration developed procedures to educate its patients to check-in more closely to their scheduled appointment times.

The results obtained by applying the SSQS methodology had successfully reduced the waiting of clinic patients and, hence, had achieved the original timeliness standard goal. It was believed that achieving this goal would increase patients' satisfaction (Martha T. Ramirez Valdivia et. al.,1997). [104]

Mohamed M. Mostafa (2005) investigated how patients perceived service quality in Egypt's public and private hospitals and also tested the SERVQUAL dimensions in hospitals within an Arab, non-Western context. The results highlighted a three-factor solution for the SERVQUAL instrument with 67 per cent of variance explained. Their result did not supported the five-component original SERVQUAL. The model was found to be significant in explaining patients' choice of the type of hospital. The major implication of the study was that the use of quantitative methods alone is valuable in establishing relationships between variables, but is considered weak when attempting to identify the reasons for those relationships. Patients may have a complex set of important beliefs that cannot be captured in the questionnaire (Mohamed M. Mostafa, 2005). [105]

Neil Drummond et. al., (2001) examined relationships between the macro-levels, meso-levels (healthauthority level), and micro-levels in the National Health Services (NHS) at the end of the fundholding period and considered its contemporary implications for Primary Care Groups (PCGs) and Local Health Care Co-operatives (LHCCs). Their findings suggested that Fundholding achieved some success in challenging the way in which services were provided at the micro-level (the practice), but had a less marked effect in terms of changing services provision at the health authority (meso - health authority level) level or in developing collaborative working with trusts and health authority in strategic decision making. Fundholding had an impact on service configuration and delivery in different ways which includes, it had small effects on overall (macro- and meso- health authority level) service provision in most areas; it made a difference to the care offered to some patients, in terms of access to specialist consultations or to professional allied to medicine (micro-level); and while it was accused of undermining the equity of health care at local level, its overall impact on equity is likely to have been modest because it achieved relatively little change (at meso-level) in service provision (Neil Drummond et. al.,2001). [106]

Prof. (Dr.) Parimal H. Vyas & Shri P.D. Thakkar (2005) conducted an empirical study and reported on selected patients' satisfaction who were drawn from Government Hospitals (GHs); Trust Hospitals (THs); as well as Private Hospitals and Dispensaries (PHs) located at Baroda during the year 2001-2002, and they had offered Comparative Market Performance Analysis of selected type of hospitals that is GHs, PHs, and THs to reflect upon its performance with regard to delivery of patients' satisfaction. Overall, it was found that patients' most favourably reported their own decision as the most important reason followed with suggestions by relatives, family doctors and non-availability of such hospital. Majority of the patients of the selected hospitals had rated performance as 'Good' in case of staff service attributes, but in case of GHs quickness was rated as Fair.

The patients' of GHs revealed dissatisfaction on majorities of the selected health care service features whereas mixed feelings were inferred by patients' in THs and PHs the patients of PHs were found relatively better satisfied followed with THs than GHs (Prof. (Dr.) Parimal H. Vyas & Shri P.D. Thakkar, 2005).[107]

Stephen A. Kapp, Jennifer Propp (2002) attempted to addressed a gap in the literature regarding the satisfaction of parents with children in foster car, for the purpose of examining the current system of gathering information on customers' satisfaction about the foster care services provided by private service contract agencies, and using these information to develop a more effective consumer satisfaction survey and protocol, based on the voices of consumers. Eight focus group were developed and data were collected and themes that emerged includes concern related to service provider viz., communication; availability; respect; parent caregiver involvement rights, and satisfaction survey comments. Theses themes that emerged relate not only to the development of a satisfaction instrument and protocol, but to the experience of having a child in the foster care system (Stephen A. Kapp, Jennifer Propp, 2002).[108]

Robert J. Casyn et. al. (2003) conducted study in which involved participants suffered from severe mental illness and were homeless at baseline, investigated on some major questions. It concluded that when two choices were nearly equal in attractiveness respondents experience the greatest amount of freedom, and consequently the greatest amount of personal responsibility for their choice. It indicated that positive expectancies and the alternative choice variables were fairly independent of each other. Thus, a client can simultaneously have positive expectancies about the chosen program, and still be attracted to another program (Robert J. Casyn et. al., 2003).[109]

Yvonne Webb et. al., (2000) evaluated patients' experience using the Your Treatment and Care assessment tool that showed that many patients did not have a copy of their care plan and had not been involved in the care planning procedure. Many reported shortcomings in their experience of their key worker and their psychiatrist. However, there was substantial variation in experience across services. It showed good internal reliability was acceptable to users and appeared to be able to access actual experiences better than a traditional satisfaction item (Yvonne Webb et. al., 2000).[110]

Syed Saad Andaleeb (1998) proposed a study to test a five-factor model that explained considerable variation in customers' satisfaction with hospitals and included factors such as communication with patients; competence of the staff; their demeanour (act or behave in a specific or cheap way); quality of the facilities, and perceived costs. The results indicated that all five variables were significant in the model and explained 62 per cent of the variation in the dependent variable.

The findings suggested that hospital customers accord great importance to the demeanour (act or behave in a specific or cheap way) of the staff, a multi-attribute construct that must be instilled and inculcated, much like an attitude, among the staff (Syed Saad Andaleeb,1998). [111]

An Emergency Nurses Association (ENA) Board of Directors (2005) discussed the customer service and satisfaction in the Emergency Department of health care service provider. Increasing numbers of Emergence Department (ED) patient visits, delays at discharge; longer ED stays; overcrowding, and diversion to other ED facilities might have lead to decreased quality of care and patients' dissatisfaction. In the ENA National Benchmark Guide the Emergency Departments, 1,380 ED managers reported that 88 per cent of their patients rated their satisfaction with the ED as good to excellent. (ENA Board of Directors, 2005). [112]

Jill Murie, Gerrie Douglas-Scott (2004) summarised five years' experience of patient and public involvement in primary care, citing examples from the Lanark practice and Clydesdale Local Health Care Co-operative (LHCC) in Lanarkshire, Scotland. It also provided an overview of some of the challenges to and opportunities for meaningful patient and public involvement. It described initiatives which involved patients and the public in the design, delivery and quality of local health care. By adopting principles derived from clinical governance significant event analysis; audit, and risk management; needs assessment surveys; consultation and health promotion lifestyle change; community development; effective dialogue between health professionals, patients, and the public had been established. The Positive outcomes reported were effective dialogue between health professionals, patients and the public, service developments and quality improvements (Jill Murie, Gerrie Douglas-Scott, 2004). [113]

C.Renzi, D.Abeni et. al., (2001) examined factors associated with patients' satisfaction with care among dermatological outpatients in which participants were recruited during at the out-patient clinics of the Istituto Dermopatico dell'Immacolata (IDI) (Rome, Italy). 396 completed the study and overall satisfaction was reported by 60 per cent of patients and the likelihood of overall satisfaction increased by the physician's ability to give explanations and to show empathy for the patients' condition, and by the older age of patients. The likelihood of satisfaction also increased with increasing disease severity, but decreased with symptom-related poor quality of life. The lowest level of satisfaction was found among patients whose symptom-related quality of life was worse than the clinical severity rated by the dermatologist. Improving the physician's interpersonal skills can increase patient satisfaction, which is likely to have a positive effect on treatment adherence and health outcomes. Dermatologists succeeded better in establishing a good relationship with clinically more severely affected patients than with patients who were clinically mildly affected despite their quality of life being impaired (C.Renzi, D.Abeni et. al. 2001). [114]

Christina C. Wee et. al.(2002) examined whether obesity is associated with lower patients' satisfaction with Ambulatory Care among 2,858 patients seen at 11 academically affiliated Primary Care Practices in Boston and completed a telephone survey during August 1996 to October 1997. Obesity is associated with only modest decreases in satisfaction scores with the most recent visit, which were explained largely by higher illness burden among obese patients (Christina C. Wee et. al., 2002). [115]

Michel Perreault et. al. (2001) verified whether information on services would appear as a distinct dimension of satisfaction in a multidimensional scale. The findings suggested that not only it was important to consider information as a distinct dimension of satisfaction but it was equally important to examine three categories, consisting of satisfaction with information on; patients' problems/illness; distinct treatment components such as medication and psychotherapy; and patients' treatment progress (Michel Perreault et. al., 2001). [116]

Senga Bond, Lois H Thomas (1992) assessed patients' satisfaction with the care they received assumed greater importance and satisfaction with nursing was no exception. With the introduction of consumer - orienentated recommendations, the emphasis on measuring patient satisfaction with health care delivery is unlikely to decrease. Furthermore, there is a need for nursing to ascertain how it affects patient outcomes, of which patient satisfaction was the most frequently measured. (Senga Bond, Lois H Thomas, 1992). [117]

Karin Braunsberger, Roger H. Gates, (2002) investigated whether there existed any relationship between patient health status and satisfaction with care, and found those who perceive system performance to be high and those with lower levels of system usage were more satisfied with both their healthcare and health plan than their opposite counterparts. (Karin Braunsberger, Roger H. Gates, 2002). [118]

Dawn R. Deeter-Schmelz, Karen Norman Kennedy (2003) investigated the role of one component of team dynamics that is cohesion of the people to stick together and remain united in the pursuit of its objectives. The research revealed a strong link between team cohesion and the quality of patient care, which in turn associated with patients' satisfaction. (Dawn R. Deeter-Schmelz, Karen Norman Kennedy, 2003). [119]

Ingrid Hage Enehaug (2000) considered to evaluate whether patients' participation with health care service provider requires a change of attitude or not? Partnership founded on equality and mutual respect. In the health care the balance of power between the patient and the healthcare professional rarely observed. By focusing on interpersonal relationship health partner ship can be created. To understand the system and be able to change the system healthcare professionals look at it from the patients' point of view that is, change of attitude in healthy care. Healthcare providers need to select, plan, and execute their own behavioural changes; create a system based on the premises of the consumers; establishing a patient/ relative panel for creating an arena for building partnerships with patients.

By combining professional knowledge with systematic input from experienced consumers the hospital organization can get access to valuable knowledge and insight to improve the care for the patients (Ingrid Hage Enehaug, 2000). [120]

Janice Nicholson, (1995) examined the concept of patient-focused care and how it fits into Hospital Process Re-Engineering. The conclusion was made that patient-focused care was as an important development process which helped hospitals to redesign the care processes. Patient-focused care and hospital process reengineering are both about a fundamental change in culture and attitude. (Janice Nicholson, 1995). [121]

Douglas Amyx et. al. (2000) examineed the relationship between the patients' freedom to choose a physician, the outcome of treatment and the patients' satisfaction. The study yielded four major findings. First, patients who experienced a good health outcome were significantly more satisfied than patients who received a bad health outcome. Second, patient satisfaction ratings differed significantly only in the bad outcome condition, suggesting an outcome bias. Third, patients who were given the freedom to select a physician but did not receive their chosen physician were least satisfied. Fourth, there was no difference in satisfaction between patients who had a choice of physician and those who did not. The results indicated that the freedom to choose a physician may not be as important to patients as originally thought. Patients did not discriminated between having or not having a choice of physician (Douglas Amyx et. al., 2000). [122]

Beach MC et. al. (2005) undertook study which included 59 primary care physicians and 65 surgeons. A total of 1265 office visits were audio taped and evaluated for statements that described a physician's personal experience that had medical or emotional relevance for the patient. Self-disclosure- that is, sharing a personal story with patients - is perceived favorably by patients of surgeons but less so by patients of primary care physicians. In this non-randomized study in which physicians occasionally self-disclosed, patients' perceptions of their physician's warmth and friendliness, reassurance and comfort, and their degree of satisfaction with their visit increased with disclosure by surgeons but decreased with disclosure by primary care physicians (Beach MC et. al., 2005). [123]

Benjamin G. Druss et. al., (1999) examined the association between administrative measures and quality of care at both an individual and a hospital level. The results revealed that at the patient level, satisfaction with several aspects of service delivery was associated with fewer readmissions and fewer days readmitted. Better alliance with inpatient staff was associated with higher administrative measures of rates of follow-up, promptness of follow-up, and continuity of outpatient care, as well as with longer stay for the initial hospitalization (Benjamin G. Druss et. al., 1999). [124]

Ingemar Eckerlund et. al. (2000) analyzed the preferences, satisfaction and actual cost-benefit valuation of provided health care services as they were explicitly perceived by the patients. The results obtained from the empirical survey pointed out at improvements where both the satisfaction and the willingness to pay were strong. It was seen that most of the major improvements proposed in the health personnel – patient relationship were more expensive to implement than the patients were willing to pay for (Ingemar Eckerlund et. al., 2000). [125]

Viroj Tangcharoensathien et. al., (1999) compared patients' perceptions of quality of inpatient and outpatient care in hospitals of different ownership in order to explore how patients' payment status affected patients' perception of quality. Its results indicated that clear and significant differences emerged in patient satisfaction between groups of hospitals with different ownership. Non-profit hospitals were most highly rated for both inpatient and outpatient care. For inpatient care public hospitals had higher levels of satisfaction amongst clientele than private for-profit hospitals. For both inpatient and outpatient care the private non-profit hospitals were highly appraised, but whereas public hospitals were generally better thought of than private for-profit hospitals for inpatient care, the reverse was true for outpatient care. The only dimensions in which private for-profit hospitals out-performed public hospitals for inpatient care was with respect to the amenities available, such as comfort of surroundings, availability of chairs etc. (Viroj Tangcharoensathien et. al. 1999). [126]

The Department of Defense (DoD) in US was concerned about how well military medical treatment facilities in the military health system performed. The proposed theoretical model for a patients' satisfaction attitude consisted of three main components that is, the individual patient, the object of the care itself and associated beliefs as well as the situation in which the care occurs. The overall level of perceived satisfaction was good over the years surveys were used. The model demonstrated the use of examining demographic and attitudinal components of patient satisfaction in military medical facilities (A. David Mangelsdorff, Kenn Finstuen, (2003). [127]

Claire Batchelor et. al. (1994) examined how consumer evaluation studies of health-care services should best be undertaken both to elicit patients' views adequately and to provide information that managers can act on. It proposed appropriate methodological guidelines and provided suggestions for the conduct of future research. (Claire Batchelor et. al., 1994). [128]

Joby John, (1992) established that prior experience with health care had a significant influence on patients' evaluative outcomes in a subsequent health care experience: on perceived quality, on satisfaction with that health care experience, and on behavioral intentions after that future health care experience. Because these patients' evaluations were influenced significantly by prior experiences through patient expectations, the hospital must attempt to condition patient expectations before and during the hospital experience (Joby John, 1992). [129]

Daniel Simonet, (2005) reviewed patients' satisfaction and they described the US history of managed care and its effect on the satisfaction of several patient categories including the general population, vulnerable patients and the elderly. Much information available on patient satisfaction with their insurers and most surveys indicated the lack of choice of a provider which was to be considered as a major source of discontent. Therefore, patients' protection laws are necessary to avoid abuse. Patients have little ability or are not willing to rely on the information available when selecting a provider. Increased media attention may boost public confidence in utilizing rankings and evaluation of health care providers (Daniel Simonet, 2005). [130]

Carobne Haines, Helen Childs, (2005) developed and implemented a user friendly, evidence-based survey tool that addressed the key concerns of parents who accessed the Pediatric Intensive Care (PIC) service. Respondents provided suggestions. for service development, particularly regarding information, communication and preparation for the transition from PIC to ward environments (Carobne Haines, Helen Childs, 2005). [131]

Kathryn Frazer Winsted (2000) examined behaviors of doctors that influenced patients' evaluation of medical encounters. It examined such behaviors in both the USA and Japan. Behaviors were grouped, using factor analysis from consumer surveys, into four dimensions in the USA viz., concern; civility; congeniality, and attention and five dimensions in Japan viz., concern; civility; congeniality; communication, and courtesy. Despite many differences in the cultures of these two countries and their medical delivery systems, many similarities were found in how consumers evaluated medical services in these two countries. Measures included some concepts including conversation; genuineness; attitude, and demeanor. These dimensions and constituent behaviors provided a framework for future research and medical training and management. Clearly, there is vast similarity between the behaviors that most relate to satisfaction in these two countries, but, there are some differences also. For the USA encounters, the top three behaviors in terms of correlation to satisfaction were caring, sincere, and pleasant. For the Japanese encounters, the behaviors most related to satisfaction were pleasant, nice and attentive. The Japanese seemed much more concerned about speed of service than the Americans (Kathryn Frazer Winsted, 2000). [132]

Gregor Hasler et. al., (2004) investigated the influence of diagnosis, type of treatment, and perceived therapeutic change on patients' satisfaction following psychiatric treatment for non-psychotic, and Non-substance-related disorders. The results showed that patients' with somatoform, eating, and personality disorders were less satisfied than patients with affective, anxiety, and adjustment disorders. Symptom reduction and changes in the interpersonal domain were important outcomes associated with patients' satisfaction.

Although, pharmacotherapy itself was not related to patients' satisfaction, patients who perceived improvements in pharmacotherapy as one of the most important treatment outcomes were less satisfied than others. Preliminary evidence showed that coping with specific problems and symptoms is associated with satisfaction among male patients (Gregor Hasler et. al., 2004).[133]

A. Breedart et. al., (2003) reported on a cross-cultural comparison of the Comprehensive Assessment of Satisfaction with Care (CASC) Response Scales. They investigated what proportion of patients wanted care improvement for the same level of satisfaction across samples from oncology settings in France, Italy, Poland and Sweden, and whether age; gender; education level, and type of items affected the relationships found. Across country settings, an increasing percentage of patients wanted care improvement for decreasing level of satisfaction. However, in France a higher percentage of patients wanted care improvement for high-satisfaction ratings whereas in Poland a lower percentage of patients wanted care improvement for low-satisfaction ratings. Age and education level had a similar effect across countries (A. Breedart et. al. , 2003).[134]

Amina T. Ghulam et. al. (2006) assessed patients' satisfaction with the preoperative informed consent procedure in obstetrics and gynecology. Most of the patients considered the written and oral information to be good or excellent, and more than 80 per cent did not desire further written Information. Forty-five percent had preferred to receive the structured information the same day the decision to undergo an invasive procedure was made, and more than half of the patients were reassured by the information provided. The combined written and oral preoperative information presented was well adapted to patients' informative wishes and needs; it allowed for a structured conversation, facility of documentation, and offering valid legal proof that adequate information has been provided (Amina T. Ghulam et. al., 2006).[135]

Cathy Shipman et. al. (2000) compared patients' satisfaction with co-operative, General Practitioner (GP) practice-based and deputizing arrangements within one geographical area 15 months after a co-operative had become established; and with telephone, Primary Care Centre and Home Consultations within the co-operative. There were no significant differences between organizations in terms of overall satisfaction, but patients using practice based arrangements were significantly more satisfied with the waiting time for telephone consultations; and more satisfied with waiting times for home visits than deputizing patients. Within the co-operative, overall satisfaction, satisfaction with the doctor's manner and with the process of making contact was greater among those attending the primary care centre, and satisfaction with explanation and advice received greater than for patients receiving telephone consultations alone (Cathy Shipman et. al., 2000).[136]

Jafar A. Alasad, Muayyad M. Ahmed (2003) investigated patients' satisfaction with nursing care at a major teaching hospital in Jordan. The findings showed that patients in surgical wards had lower levels of satisfaction than patients in medical or gynecological wards. Gender, educational level, and having other diseases were significant predictors for patients' satisfaction with nursing care (Jafar A. Alasad, Muayyad M. Ahmed, 2003). [137]

Ruth Belk Smith et. al., (1986) conducted study for the American College of Obstetricians (OB) and Gynecologists (GYNS) by a commercial marketing research firm. Its results showed that patients seemed quite satisfied with scheduling of appointments; helpfulness of the staff; received sufficient information on billing and insurance procedures; thought fees charged were reasonable. Where as Open-ended responses indicated, however, that a number of patients had to wait too long to get an appointment and requests were made for more varied hours as well as for receptionist to inform by telephone and in person if the doctor was running far behind schedule; less satisfaction with the staff, requesting more respect, friendliness, and more satisfactory information; fees were considered too high in relation to the short amount of time spent with the physician (Ruth Belk Smith et. al., 1986). [138]

Giuseppina Majani et. al., (2000) assessed patients' satisfaction about everyday life. In Satisfaction profile (SAT-P), 732 patients were asked to evaluate their own satisfaction level on 32 daily life aspects concerning their last month experience. The factor analysis extracted 5 factors viz., Psychological functioning; physical appearance; type of work; social functioning. test-retest reliability; pearson's coefficients were used and all together with the user friendly structure, the brief administration and scoring time, the simple graphic representation, suggested to consider the SAT-P a useful complementary tool in Health Related Quality of Life (HRQOL) assessment (Giuseppina Majani et. al., 2000). [139]

Nancy Gregory, Dennis O. Kaldenberg (2000) developed and illustrated a psychometrically sound survey that measured patients' satisfaction with a facility's billing process. The data for this study were based on responses from 496 patients representing both inpatient and out patient experiences. The survey included questions about bills received; interaction with business office staff; billing procedures followed, and personal issues dealing with the patients' understanding of the billing process and explanations given by staff. Factor analysis generated a relatively clean, five-factor solution and these factors were labeled as viz., bills for services, staff, procedures, personal issues, and other ratings (Nancy Gregory, Dennis O. Kaldenberg, 2000). [140]

Joanne Coyle, Brian Williams (1999) clarified concept of dissatisfaction by examining what studies of patients' satisfaction can and cannot tell us about dissatisfaction. The resources directed towards satisfaction surveys may not be well spent. The lack of conceptual clarity and inadequate theorization are the key problems facing patients' satisfaction research. This led to a number of unwarranted assumptions being made about the concept of satisfaction and to the neglect of dissatisfaction.

Many people may willingly express dissatisfaction, and yet not make any form of complaint. The aim of review was to question the implicit assumptions made about dissatisfaction in patients' satisfaction research and, to move towards a definition of dissatisfaction. It was argued that researchers should not assume that dissatisfaction and satisfaction are the opposite ends of the same continuum; the expression of dissatisfaction represents a negative evaluation of health care; and dissatisfaction results from the failure to meet expectations. Instead dissatisfaction considered to be subjective transformation, complicated and involves the crystallization of a strong, undifferentiated, vague, negative emotion experienced immediately into a more stable negative interpretation of the experience. Further, categories such as power, control, attributions, and personal value/worth are complex variables which intervene between the experience of untoward events and the expression of dissatisfaction (Joanne Coyle, Brian Williams, 1999). [141]

Patrick M. Baldasare (1995) conducted focus group interviews among the members of Mercy Health Plan in 1994 to understand what Medicaid patients meant by the term quality of care. Two surprising themes emerged in the research. First, it was found that issues related to empathy, and respect dominated the focus group discussions. Second, even issues that were not typically related to respect were interpreted in light of the respect issue. In addition to the technical quality of care, these patients reckoned with a larger issue that is, seeking respect, equal treatment, and empathy from the care provider (Patrick M. Baldasare, 1995). [142]

M.A.A. Hasin (2001) attempted to determine an elements of customers' satisfaction, by collecting information through survey, using both written questionnaire and interview, and then statistically determining correlation between factors and elements of dissatisfaction. It was found that though the hospital had a good level of overall service, there were many areas that needed attention for further improvement of the hospital services. Some of the factors which were found necessary at this specific hospital, were viz., change in attitude of employees; training at all levels; breaking of the departmental barrier, and absence of policy that was needed to be resolved (M.A.A. Hasin, 2001). [143]

Dawn Bendall-Lyon et. al. (2004) linked satisfaction with structure and process attributes to global satisfaction and behavioral intentions. The authors developed and presented a Structural Equation Model that encompasses these relationships based on a survey of 635 consumers of healthcare services who received inpatient medical services at a teaching hospital affiliated with a Carnegie I extensive research university. The results indicated that satisfaction with both structure and process attributes had a significant impact on global satisfaction. Global satisfaction was found to directly influence both intention to recommend and intention to return to the healthcare service provider. Its results indicated that structure is as important as process, and satisfaction with service delivery had influenced equally in case of both of these elements (Dawn Bendall-Lyon et. al., 2004). [144]

Dawn Bendall Lyon et. al. (2003) evaluated an impact of mass communication and the passage of time on consumer satisfaction and loyalty in a high-involvement service setting. The study was based on a survey of two groups of individuals, who received inpatient medical services at a teaching hospital affiliated with a Carnegie Level One Research university. First group included a short-time lag group consisted of individuals who were surveyed immediately after receiving a service and one year letter. A long-time lag group consisted of individuals who were surveyed immediately after they received a service and two years later. Satisfaction and loyalty decreased from the initial time of the service encounter for both the short-time and long-time groups. While satisfaction and loyalty declined over time for both groups, the results revealed no difference in the change in satisfaction between the two groups. In addition, exposure to mass communication did not influence the change in satisfaction and intention to return over time (Dawn Bendall Lyon et. al. , 2003). [145]

Jessie L. Tucker, (2002) determined whether the patients' socio-demographic, health status, geographic location, and utilization factors predict overall patient satisfaction with health care in military facilities at Department of Defense (DOD) in USA. Its findings suggested that patient-specific factors predicted patients' satisfaction after controlling for factors depicting patients' evaluations of health system characteristics (control variables). Patient specific factors provided added, although very minimal, explanatory value to the determination of patients' satisfaction (Jessie L. Tucker, 2002). [146]

Karin Newman, et. al., (2001) examined the complex issue of nurse recruitment; retention; healthcare quality, and patients' satisfaction for UK National Health Services (NHS). The study described a generic conceptual framework or chain derived from a review of the literature on nurse recruitment and retention; service quality and human resource management. The patients' satisfaction chain was made up of components which included, NHS and Trust; conditions and environment (internal quality); service capability; nurse satisfaction; nurse retention; quality of patient care; and patient satisfaction. Its key findings indicated that customer service was a pre-requisite for customer satisfaction; employees play a key role in the provision of service; employees influence the quality of, and delivery of products and services; evidence of a positive relationship between employee satisfaction and customer satisfaction (Karin Newman, et. al., 2001). [147]

Mayo, Harrah (2004) provided their views on keeping very satisfied customers by following the notion 'The Customer is always Right'. The company policy, a rule, that never bended to consider the customer or patient comes first in all consideration. Such slogan provided an opportunity not merely as an advertising slogan. Staff in the hospital must be clean and immaculately presented down to the minor details because the hospital and their brand. Hospital creators should insist on backing up extensive medical knowledge and up to the minute healthcare with constant visual and experiential clues.

Hospitals should be never considered by a patient a nice place to visit, and so make every effort to put patients at ease within their surroundings before they even see a physician. (Mayo, Harrall's, 2004).[148]

Suzanne C. Tough et. al. (2004) made an attempt to describe the demographic and lifestyle characteristics of women who had recently delivered a live-born infant. It also determined if satisfaction with prenatal care was related to self-reported emotional health prior to pregnancy. The study concluded that patient assessment of satisfaction with prenatal care may be related to both self-reported emotional health and delivery of medical care. Identifying and addressing emotional health of prenatal patients may improve compliance with medical recommendations, ultimately improving health outcomes (Suzanne C. Tough et. al., 2004).[149]

Charles Zabada et. al. (2001) pointed out the growing importance of the concept of patients' satisfaction, and suggested that one of the ways to improve patients' satisfaction rating was to put more emphasis on the use of appropriate Information Technology in the delivery of healthcare. A framework through which improvement can happen is designed to help managers conceptualize the process. They had developed four-category classification, which offer dimensions that can provide managers with a framework well amenable to Information technology, includes, interaction evaluation, competence evaluation, financial transaction evaluation, and facilitating factor evaluation (Charles Zabada et. al., 2001).[150]

Mary Draper, Sophie Hill, (1995) reported on the feasibility of national benchmark questions for patients' satisfaction surveys. The substantive intent here was to reflect on consumers' perspectives within the exercise of setting National Quality Benchmarks. The purpose for undertaking consumer feedback activity needs to be articulated and owned by hospitals as part of their overall organisational strategy. There are several related issues which emerged from the consumer research included, such as communication; being treated with respect, and being involved in decision-making. For some people, access to hospital care was important which included the cost of, or the lack of public transport; they were not informed about waiting; they did not get in for some reason. Patient satisfaction surveys need to be undertaken in a context that goes beyond comparison of results to a context where hospitals use benchmarking, or other approaches, to establish what the processes are that lead to good practice (Mary Draper, Sophie Hill, 1995).[151]

James A. Hill (1969) explored the therapeutic perspectives of patients and therapists by determining the cluster dimensions of therapist goals, patient wants, and patients' satisfactions, and investigated the influence and interaction of the intention factors on the satisfactions patients reported receiving from psychotherapy. Analysis of the averages of these ratings over time revealed that patients' satisfaction was uninfluenced by patient wants, but significantly paralleled the therapist's goal-setting behavior (James A. Hill, 1969).[152]

Robert J. Wolosin, (2005) provided data that indicated general satisfaction with care provided by family physicians. Physicians themselves obtained the highest ratings, followed by nurses. Patients were less satisfied with access to care issues; items pertaining to waiting for the physician were rated the least satisfactory of all. Patient gender affected ratings of several survey items; women were more satisfied with physician-related items than were men; men were more satisfied with process-related issues than were women. If family physicians want more satisfied patients, they should show more respect for patients' time (Robert J. Wolosin, 2005). [153]

Fayek N. Youssef (1996), measured patients' expectations before admission, recorded their perceptions after discharge from the hospital, and then attempted to close the gap between them across five broad dimensions of service quality viz., tangibility; reliability; responsiveness; assurance; and empathy. Its results recorded the average weighted NHS Service Quality Score overall for the five dimensions as significantly negative. A striking result was that reliability was considered by far the most important dimension. Empathy was the second most important dimension, and was closely followed by responsiveness. Tangibility was considered the least important amongst the selected five SERVQUAL dimensions (Fayek N. Youssef, 1996). [154]

A survey on patients' satisfaction ratio at SMHS Hospital, Srinagar was conducted by Waseem Qureshi et.al. (2005) for inpatient services. The results concluded that the hospital administrators should be aware of the needs and expectations of the public as per the feedback of the public relations department and accordingly take policy decisions. (Waseem Qureshi et. al., 2005). [155]

3.2.3 Comparison of Patients' Satisfaction Amongst Hospitals:

Naceur Jabnoun and Mohammed Chaker (2003), compared the service quality rendered by private and public hospitals. It found significant difference between private and public hospitals in terms of overall service quality and the four dimensions of empathy; tangibles; reliability, and supporting skills. (Naccur Jabnoun and Mohammed Chaker, 2003). [156]

David Camilleri, Mark O'Callaghan (1998) applied the principles based on the SERVQUAL model and along with Donabedian's framework to compare and contrast Malta's public and private hospital care service quality, through the identification of 16 service quality indicators which were classified under six dimensions viz., catering; hospital environment; professional and technical quality; patient amenities; service personalization; accessibility. In Malta, the private hospital service was regarded as being of superior quality to that provided by the public sector; especially in terms of quality sentinels reflecting the augmented ("hotel") service product, but it was the public sector that was exceeding its patients' expectations by the wider margin. Both the private and the public hospital services were exceeding the corresponding customers' expectations.

In this respect, it is apparent that the expectations/ perceptions gap for the public sector is wider than that for the private sector (David Camilleri, Mark O'Callaghan, 1998). [157]

Penelope Angelopoulou et. al. (1998) conducted study to determine how do physicians and patients perceive the quality of medical services offered in the private and public sector. On the basis of a survey interesting characteristics were identified. Patients in the public sector attribute greater importance to resources of a medical and technical nature and did not seem particularly concerned about the contextual or environmental features of a hospital. Private patients were expecting a more holistic approach to their treatment and expected some attention to be directed to their emotional needs. Private surgeons were worried about the limited basic resources in private hospitals and their inability to satisfy the non-clinical needs of their patients (Penelope Angelopoulou et. al., 1998). [158]

Sandra K. Smith Gooding, (1995) explored the links between perceived quality, perceived sacrifice, and perceived value in the hospital choice scenario. The findings have implications not only for hospital strategic planning and marketing, but also for public policy makers who want to involve consumers in the health care decision-making process and determine what information they need. Suggestion based on findings included quality concerns carry significantly less weight with consumers for minor treatment than for major care; similarly, monetary and other sacrifice concerns are significantly more important for minor care than for major treatment. However, local hospitals cannot afford to dismiss the importance of perceived quality and must address any negative consumer perceptions while also emphasizing the value of location; Likewise, regional hospitals should promote the quality perception of the entire institution and its specialties while minimizing the sacrifice of longer travel times, etc. in consumer messages (Sandra K. Smith Gooding, 1995). [159]

3.2.4 Patients' Satisfaction and Customer Relationship Management:

B.Krishan Reddy, G.V.R.K. Acharyulu (2002) conducted the study aimed at presenting some of the CRM concepts and elements to formulate CRM strategy in order to take proactive measures towards customer-centric business in a corporate hospital to improve customer satisfaction by building up better customer relationships leading to increase in revenues. This study focused on the Master Health Check (MHC) Packages, profile of customers, and their behaviour and finally determined the relationship factors to design CRM strategy. It found that the reason for maximum number of customers opting for MHC and Executive Health Check were due to Heart Check and Well Women Check were specialized packages confined to only specific purpose; Master health Check is highly demanded because it provided the customers with a list of comprehensive tests and it was also economical (Rs. 1700) compared to the other package; and Executive Health Check was a package that is directed only to the office going people and the executives not recommended for all (B.Krishan Reddy, G.V.R.K. Acharyulu, 2002). [160]

Markus Orava, Pekka Tuominen (2002) analysed the quality of a professional surgical service process, and revealed the main elements that constitute excellence in the experience of the surgical service of a private hospital. Empirical research was conducted in private hospitals and its results indicated that, in private surgical services, the surgical procedure itself was the single most important element, but that it must be supplemented by quality dimensions in both output and process throughout the whole surgical service process combined with deep patient-staff interaction, elements of professional expertise and pleasantness, and versatile supporting services and physical features. The need for relationship marketing was evident in private hospitals because empirical findings heavily underlined the importance of patient-staff interactions and the trusting nature of doctor-patient relationships (Markus Orava, Pekka Tuominen, 2002).[161]

Beth Hogan Henthorne et. al. (1994) described process for providing an enhanced level of service that is, the adoption and implementation of a Patient Advocacy Program. Prior to the introduction of the advocacy program, they conducted care satisfaction/complaining behavior surveys for both patient and clinic staff. Based on the findings of the initial patient and staff surveys, a three-month pilot plan was developed for a patient-oriented support service and after three months it revealed generally poor usage of patient representatives by clinic staff. Continued administrative concern about the appropriate use of the patient representatives led to further refinement of the system which includes, A permanent in-house site was established for program representatives; A plan was developed to re-sensitize staff to patient needs and aspects of patient satisfaction through additional staff in-service; A new patient letter was developed with a brief questionnaire to assess the patients' satisfaction with his or her recent clinic visit. Even though an increase in patients' satisfaction was a long-term goal of the advocacy program, the more immediate goal was to set in motion a system that addressed existing dissatisfaction in the health care environment (Beth Hogan Henthorne et. al., 1994).[162]

3.2.5 Measurement of Patients' Attitude:

Nimma Satynarayana, et. al., (2004) measured the patients' attitude towards payment an opinion survey through a structured questionnaire for a period of 2 months, with a total sample of 85 cases at the hospitals at Hyderabad. Its Findings suggested that more number of rural patients, particularly from nuclear family with mean income of Rs. 3,102.56 with male preponderance (74 Per Cent) attended the hospital. It also showed that white card holder (income <6000 per annum) dominates (52 Per Cent) the patient profile; and employed patients accounted for 61 Per Cent. It was surprising to note that 70 per cent patients were able to pay but unwilling to pay the hospital bills. The key finding of the study was that, contrary to expectation of attracting paying (middle income group) patients, the hospital was getting low income group/referral patients. In order to attract the paying patients' medical insurance policy should be considered (Nimma Satynarayana, et. al., 2004).[163]

Stephen Todd et. al., (2002) investigated the perceptions and attendant behavioural attitudes of stakeholders, including patients and visitors, to the built environments and supporting facilities provided by Salford Royal Hospitals NHS Trust, U.K. the study had used variety of methodologies to collect empirical dat which included, extensive literature survey and research review, one-to-one patient interviews, a large questionnaire survey, patients' picture stories. The empirical evidence examined suggested that the notions of patients-friendly environments held by participants in the study were based upon three conceptual visions of the role and function of the built environments of health-care facilities, which includes notions of homeliness, notions of movement and accessibility through transitional spaces, and notions of supportive environments (Stephen Todd et. al., 2002). [164]

3.2.6 Patients' Expectations/Perceptions:

Dr Sona Bedi et. al., (2004) conducted a patients' expectation survey among 230 patients who visited the outpatient departments of two Government hospitals at Delhi. Its findings suggested that in both hospitals, waiting time in physicians' queues and duration of consultation time appear to be potentially dissatisfaction causing factors. Hospital administrators of both hospitals were expected to devise strategies to mitigate the effect of these factors. Both hospitals needed to have a strategy of improving communication skills of physicians (Dr Sona Bedi et. al., 2004). [165]

Eugene C. Nelson et. al., (1992) conducted study based on 51 General Medical/Surgical hospitals owned by the Hospital Corporation of America (HCA). The findings suggested that measurable improvements in patients' judgments of hospital quality might translate into better financial performance. Its analysis confirmed that patient perceptions of quality were associated with hospital financial performance. The factor analysis revealed four clear and distinct dimensions of hospital quality which included, medical/billing; nursing/daily care; admissions, and discharge. It clearly demonstrated that meeting inpatients' expectations was associated with the financial strength of hospitals in this investor-owned health care system (Eugene C. Nelson et. al., 1992). [166]

Li-Jen Jessica Hwang et. al., (2003) conducted a survey utilizing a modified SERVQUAL instrument measured on a seven-point Likert scale was carried out on-site at four National Health Service (NHS) acute trust for evaluating the perceptions and expectations of meal attributes and its importance in determining patient satisfaction. The results of factor analysis found three dimensions i. e. food properties; interpersonal service, and environmental presentation. The food dimension was found to be the best predictor of patient satisfaction among the three dimensions, while the interpersonal service dimension was not found to have any correlation with satisfaction (Li-Jen Jessica Hwang et. al., 2003). [167]

Stefanie Naumann, Jeffrey A. Miles, (2001) conducted study based on 195 patients who visited the urgent care department of a rural hospital in Central England. The study examined the effects of three elements of process control on patients' fairness and satisfaction perceptions with the triage process means a process in an urgent care department, and such elements included viz., allowing patients to have a voice in the waiting process; informing patients the expected waiting time, and keeping patients occupied while they wait for treatment. The results demonstrated that patients who believed they had a voice in the triage process had higher fairness perceptions and waited a shorter period of time than those who believed they did not have a voice in the triage process. In addition, patients' who were told the expected waiting time and were kept busy while waiting had higher satisfaction perceptions (Stefanie Naumann, Jeffrey A. Miles, 2001).[168]

James M. Carman (2000) designed the study to provide answers to the question of how patients evaluated the quality of hospital care. It provided empirical evidence on the relative importance of the various dimensions of care and how these evaluations interacted with one another.

The study showed that consumers evaluated the technical dimensions of nursing care; physician care, and outcome as more important than the accommodation functions; accommodation, discharge and food of hospital care, and there were significant interactions among the technical dimensions. Both sets of dimensions were important and significant, but technical quality evaluations were not influenced by the perceived quality level of the affective attributes (James M. Carman, 2000).[169]

Alan Baldwin, Amrik Shoal (2003) conducted study using research methodology based upon the SERVQUAL instrument to identify service quality perceptions of dental patients. Its results suggested facets of service quality emerged as priorities for dental patients as fear and anxiety, Punctuality, waiting times, collaborative treatment planning, and opening times (Alan Baldwin, Amrik Shoal, 2003).[170]

M. Sadiq Sohil (2003) examined and measured the quality of services provided to 186 patients (out of which 150 were used for analysis) by five private hospitals across Malaysia in the first quarter of 2001. Its results indicated that patients perceived value of the services exceed expectations for all the variables measured. A comparative analysis with similar studies in other countries such as Hong Kong and Turkey, Malaysian health-care providers seemed to be doing better job in achieving customer satisfaction with regard to service quality (M. Sadiq Sohil, 2003).[171]

3.2.7 Patients' Safety/Complaints:

Thomas V. Perneger, (2006) have discussed various examples of studies on patients' safety as field of research area. Patient safety is to be considered as global problem that calls for global solutions. In-depth studies of errors, mishaps, and patient safety incidents; epidemiologic studies of incidents and errors identification of risk factors for patient safety events; research on human factors; patient involvement in safety; development of patient safety indicators; and evaluation of interventions to improve safety have been described as rich field of research that offers exciting opportunities to researchers of many disciplines. The impetus to patient safety research that will be given by the World Alliance and other governing bodies is a welcome development (Thomas V. Perneger, 2006). [172]

Didier Pittet, Liam Donaldson (2006) advocated that improving the safety of patient care shall be considered as an issue which affects health systems in both developed and developing countries. To co-ordinate and accelerate improvements in patient safety, the World Health Organization (WHO) has supported the creation of the World Alliance for Patient Safety was launched in October 2004. The six action areas of the alliance were patients for patient safety; taxonomy; research; solutions for patient safety; reporting and learning, and a biennial global patient safety challenge. (Didier Pittet, Liam Donaldson (2006). [173]

Kathleen L. McFadden et.al. (2006) explored the use of Patient Safety Initiatives (PSIs) at the US hospitals which included such approaches as open discussion of errors, education and training, and system redesign. (Kathleen L. McFadden et.al., 2006). [174]

Rachel Javetz, Zvi Stern (1996) agreed that patients provide important feedback to health-care providers and policy makers by voicing their complaints and requests. The unavoidable involvement of the customers' feedback role as a contributing factor in the endeavour for continuous quality improvement in the health-care system was emphasized. (Rachel Javetz, Zvi Stern, 1996). [175]

Sophie Y. Hsieh et. al. (2005) explored and evaluated how hospital staff responds to patients' complaints made against hospitals. It was revealed that: complaint handlers were not sufficiently empowered, information sharing was limited within the organization, communication among professional staff and with management was inadequate, the physical safety of workers had been threatened, and improvements could not be sustained. It became evident that the hospital did not use patient complaints as a source of learning that could have promoted higher standards of care. The case study revealed some of the constraints and identified requirements for appropriate use of information and feedback from patients. The study showed that hospitals need to establish clear policies and mechanism to improve their performance in complaints handling. Second, complaint handlers have to be sufficiently empowered to be able to deal with a variety of patient complaints.

Third, an effective communication network between departments is essential to follow up the procedure of complaints handling and further to enhance monitoring any improvement activities occurred within the department (Sophie Y. Hsieh et. al., 2005).[176]

3.2.8 Work Motivation for Hospital Employees:

Darren Lee-Ross (2002) assessed the reliability and rationale of Hackman and Oldham's (1975) Job Characteristics Model (JCM) among public and private sector hospitals Chefs in New South Wales, Australia, to test its appropriateness in a healthcare setting. The study also assessed the motivation of hospital chefs by comparing the perceived presence of job dimensions and motivational outcomes by using the associated questionnaire Job Diagnostic Survey (JDS). (Darren Lee-Ross, 2002).[177]

Karin Newman and Uvanney Maylor, (2002) focused on nurse satisfaction, dissatisfaction and reasons for staying to provide an empirical support for a conceptual model "The Nurse Satisfaction, Quality of Care and Patient Satisfaction Chain". The in-depth interviews revealed a spontaneous and explicit linking of organizational resources to nurses' ability to provide the level of patient care commensurate with their desire and patients' needs. Nurse Job satisfaction derived from knowing that they have provided good care as well as the attributes of the job such ads a career, skill acquisition and the people with whom they work. Job dissatisfaction stems primarily from staff shortages, the behaviour of patients and negative media comment (Karin Newman, Uvanney Maylor, 2002).[178]

John R. Welc, Brian H. Kleiner (1995) addressed three aspects of hospital management that had undergone changes owing to the environmental factors viz., cost containment, marketing strategies, and human resource management. The rising cost of health care has affected Medicare reimbursement, caused business to be a discerning selector of medical care, and given birth to alternative forms of health care delivery. All these conditions have resulted in decreased revenue and increased competition for hospitals. Hospitals have been forced to take a closer look at how they can increase revenue, cut costs, and still maintain quality patient care. Various marketing strategies were recommended such as, promotion of high-tech equipment to attract both physicians and patients; diversification into other areas (home-care)of health care delivery; Joint advertising with vendors; exploring the idea of making the patient a partner in the care experience; and retaining good employees and improving productivity (John R. Welc, Brian H. Kleiner, 1995).[179]

3.2.9 Hospital/Patients' Care Development Programme:

P.S. Raju et. al., (1995) measured market orientation and performance for the three major dimensions of market orientation that is, intelligence generation; intelligence dissemination, and responsiveness. The analysis yielded four aspects critical in assessing a hospital's market orientation: gathering information; improving customer satisfaction; responding to customer needs; and reacting to competitors' actions.

While all four elements are essential, their importance varies depending on the type of hospital performance against financial performance, market/ product development, or internal quality. Responsiveness to competition emerged as the dimension. Executives within the same hospital differed significantly in their assessments of their institution market orientation compared to the competition that has the most significant impact on all measures of performance (P.S. Raju et. al., 1995).[180]

Christine Renner, Elaine Palmer, (1999) examined the impact of an outsourced non-core service on a hospital's overall service system. Service that was outsourced and chosen for the study, namely the service delivery of Lithotripsy (diagnosis and treatment of kidney stones) in the New-Zealand. Its findings showed that the outsourced service provides access to more sophisticated technology, increases in-house capacity and saves capital expenditure. However, the outsourcing also increases the scheduling problems that the hospital faces. (Christine Renner, Elaine Palmer, 1999).[181]

Adrienne Curry et.al. (1999) used two different techniques to address the issue of consultation of stakeholder in healthcare. The two proposed approaches viz., SERVQUAL and the Nominal Group Technique on basis of which data were collected data from a variety of different stakeholder groups. The priority of dimensions emerged from study included empathy, responsiveness, reliability, assurance, and tangibles. From the Nominal Group Technique research; it was clear that the overall priority was patient-focused care, followed by organisation, communication and skilled staff (Adrienne Curry et.al., 1999).[182]

Terry R. Lied et. al. (2001) presented an approach to obtaining, developing, and evaluating performance indicators that was felt useful to small hospitals in meeting their mandates for public accountability and quality improvement. A number of measures were suggested that it could be useful in most small hospitals in assessment of performance which included, Length of Stay (LOS) by diagnosis; Acute Myocardial Infarction (AMI) mortality; time from arrival until therapy was received for AMI; use of physical restraints; emergency department wait times; Cesarean sections; patient falls; and patient satisfaction (Terry R. Lied et. al., 2001).[183]

Patient-Focused Care (PFC) was introduced to UK health-care staff by the North American Management Consultants in the late 1980. Keith Hurst (1996) conducted study which aimed to evaluate PFC in eight UK pilot sites; to assess the impact of PFC on patients, relatives, and staff; to measure the clinical, managerial, patient, and staff gains in PFC settings; explore the set-up, maintenance, opportunity, and managerial costs in PFC units. The results from the analysis and synthesis of data fell naturally into the PFC elements which included, operating units and patient groups; decentralizing services: placing them closer to patients; multiskilled and cross-trained staff in special care teams; care protocols and integrated patient records; and costs (Keith Hurst, 1996).[184]

Jane McCusker et. al. (2004) confirmed five proposed sub-scales from the Nursing Work Index – Revised (NWI-R) aimed to assess the nursing work environment and the performance of these sub-scales across different units in a hospital. It suggested that several work environment sub-scales, particularly "resource adequacy", but also "nurse manager ability" and "nurse-physician relations" may be useful tools for management to monitor the environment for nursing care within a hospital and to assist in the development of quality improvement strategies (Jane McCusker et. al., 2004).[185]

Pratik Hill et. al. (2000) described the strategy designed to maximize staff involvement in capturing user views, in order to develop services at a district general hospital. The strategy Patient Care Development Programme (PCDP) provided a framework for both staff and patient involvement in shaping and influencing the development of health-care services. The PCDP had achieved its aim in that it enabled multidisciplinary teams to produce plans for service development based on information obtained from the patients, and their relatives. The programme had also demonstrated its value in terms of organizational development, staff involvement and the practical application of a qualitative methodology, sensitive enough to explore the patient experience in a meaningful way. The evaluation of PCDP had supported the decisions to adopt a qualitative approach; maximize staff involvement; and work with multidisciplinary teams (Pratik Hill et. al., 2000).[186]

Karin Newman (1997) adopted case study method by combining analysis and interpretation of hospital documents, semi-structured interviews with the chief executive and training and development manager and the staff of the medical unit, together with observation of the units during the summer of the year 1996 in the Kington Trust Hospital, U.K. (Karin Newman, 1997).[187]

Syed Amin Tabish (1998) discussed on development of professional management in Indian Hospital in order to innovate superfine quality in professional management that was advisable to introduce specialised research studies, monograms, case studies and open discussion of views on varying issues to generate openness in presenting the need for development in hospital management services. (Syed Amin Tabish, 1998).[188]

George E. Kempton (1996) described a major programme of change embarked on by Kingston Hospital NHS Trust, UK in 1992 that was aimed to deliver care to its patients more effectively and efficiently. Five key issues that had to be addressed were identified in the review of services if the hospital was to deliver Patient-Focused Care (PFC). These were, viz., delayed service delivery; depersonalized and fragmented service; centrally-based and functionally managed services which resulted in excessive administration, diverting time, effort and resources from patient care; and a large amount of patient-related activities being undertaken by the least trained staff or those still undergoing training. (George E. Kempton, 1996).[189]

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