PATIENTS' SATISFACTION MEASUREMENT - HYPE OR HOPE : A CRITIQUE

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ABSTRACT

Patients' satisfaction measurement stands to play a crucial role amongst the health care providers. As physicians and hospitals have begun to experience increased pressure for the delivery of quality of hospital or medical services as well as enhancement of the patients' safety at an affordable cost which calls for greater attention and accountability amongst the health care professionals. The concept, philosophy and application of the patients' satisfaction measurement need to be further integrated into an overall measure of its clinical quality. Variation in Patients' satisfaction measurement tools, however, is an obstacle considering aspect of instrument's reliability part of the quality equation. At present, data on patients' satisfaction is gathered by various entities, for different purposes and at different levels in the health care system for designing of health plans, hospitals and medical practices. The most commonly and largely used method for patients' satisfaction measurement is conducting of customized surveys to assess and improve its hotel-motel functions for ensuring delivery of a better medical or hospital service to maintain an apt stance in competitive health care market. The patients' satisfaction measurement is mainly based on improvement services, and use of available patients' discharge information for selection of a sample supported with use of focus group in few cases used to develop better insight on it. In few cases, a consultant division also keeps abreast of any changes in the medical or healthcare industry that might warrant alterations as data on patients' satisfaction measurement can play crucial role in the strategy formulation and in application of business tactics by the medico professionals and hospitals in designing and delivering of medical or hospital services to patients.

Keywords : *Patient satisfaction, Measurement, Competitive health, Medico Professional, Health care environment.*

In a competitive health care environment, patients' want and expect better health care services than they did in the past, and medical centers are concerned about maintaining their overall image. The results of patient satisfaction surveys are used by hospitals to arrive at benchmarks for best practices across hospitals within the health system, using the data to make adjustments in areas such as efficiency of the admissions process, managing admission of patients' to a clinical unit or bed, and maintaining sensitivity to the needs of patients'. Information on patient satisfaction can also be for quality monitoring and

improvement efforts at its clinical practices (Christopher Guadagnino, 2003).

RATIONALE & METHODOLOGY

An attempt has been made in this conceptual paper to critically appraise on emerging issues and challenges concerning patient safety to showcase that patients have been suffering or dissatisfied mainly due to carelessness of healthcare service providers. This paper offers a comprehensive but critical appraisal on the healthcare sector of India with a specific and clear thought on 'Patient Satisfaction Measurement' based on significant review of literature. It calls for a broad-minded approach with a heavy emphasis on multy-party deliberations, consultative and collaborative discussion on issues confronting standardization of measurement of patients' satisfaction; a need for standardization in patients' satisfaction measurement in hospital services, and quality diamond model of patient satisfaction resultant into grave hard work for improving patients' satisfaction and up-liftment of initiatives for strengthening the most crucial aspect of health care that is patient satisfaction.

A Brief Review of Health Sector of India: An attempt to put forward an overview on the health care sector of India is being made on basis of available factual data concerning Health Care Indicators of India, Infrastructure for health, and Expenditure incurred for the Health Care Sector although in case of certain selected health indicators, India has improved substantially during 1951 to 2001. The efforts of Government of India for providing the safer and healthy environment can be witnessed in form of an introduction of various Government programmes, policies, and legislations implemented from time to time. One can find continuous improvement in various health indicators from the year 1951.To illustrate, life expectancy had reached to 64 years; the Infant Mortality Rate (IMR) has fallen to 63 per 1,000 Populations; Crude Birth Rate has declined to 25 whereas Crude Death Rate has fallen to 8.1. (J. Kishore, 2006). As per the Report "Macroeconomics and Health, 2005" of the National Commission, longevity in India had reached to 66 in the year 2004 whereas IMR has declined by over 70 per cent in the year 1990.

Besides, the favourable changes were observed in case of selected diseases such as Malaria which has been contained at 20 lakh cases. Smallpox and Guinea-warm have been completely eradicated, and Leprosy as well as Polio has reached to nearly state of elimination. A significant improvement in the Quality of Health Care over the years becomes evident as shown in Table Number 01. Crude Birth Rate (Per 1000 Population) has induced from 40.8 in the year 1951 to 23.1 in the year 2007. Crude Death Rate (Per 1000 Population) has declined from 25.1 in the year 1951 to 7.4 in the year 2007. Similarly, Total Fertility Rate (Per Woman) had gone down from 6.0 in the year 1951 to 2.8 in the year 2006. IMR (Per 1000 Live Births) had reduced from 146 of the year 1951 to 55 in the year 2007. Child (0 to 4) Mortality Rate (Per 1000 Children) was 57.3 in the year 1972 which has reduced to 17.3 in the year 2006.

The Life Expectancy at Birth for Males had increased from 37.2 in year 1951 to 62.6 during years 2002 to 2006. The Life Expectancy at Birth for Females had increased from 36.2 of the year 1951 to 64.2 during years 2002 to 2006. (The Economic Survey, 2006-2007, 2007 – 2008 & 2008-2009). During years 2000 to 2005, over 1, 00,000 deaths have been averted due to the up scaling of Directly Observed Treatment Short-Course (DOTS) (Ibid).

The progress has not only been observed in case of selected

Table 1: Selected Health Indicators in India

Sr. No.	Selected Indicators	1951	1981	1991	Current level
01	Crude Birth Rate (CBR) (Per 1,000 Population)	40.8	33.9	29.5	23.1 (2007)
02	Crude Death Rate (CDR) (Per 1,000 Population)	25.1	12.5	9.8	7.4 (2007)
03	Total Fertility Rate (TFR) (Per Woman)	6.0	4.5	3.6	2.8 (2006)
04	Maternal Mortality Ratio (MMR) (Per 1,00,000 live births)	NA	NA	437 (1992-1993) NFHS	254 (2001-2004)
05	Infant Mortality Rate (IMR) (Per 1,000 live Births)	146 (1951-1961)	110	80	55 (2007)
06	Child (0 to 4) Mortality Rate (Per 1,000 Children)	57.3 (1972)	41.2	26.5	17.3 (2006)
07	Couple Protection Rate (In Percentages)	10.4 (1971)	22.8	44.1	48.2 (1998-1999)NFHS
08	Life Expectancy At Birth	37.2	55.4	59.0	62.6
	[8.1] Males		(1981-1985)	(1991-1995)	(2002 – 2006)
	[8.2] Females	36.2	54.7	59.7 (1991-95)	64.2

Source: The Economic Survey 2006 – 2007, 2007-2008 & 2008 – 2009.
NFHS: National Family Health Survey; NA: Not Available.

health indicators and diseases but the Indian health care is considered best at the global level. Indian doctors are comparable to the best in the world as they are technically proficient, and capable of performing sophisticated procedures and that too at a fraction of the cost available in the west (Ministry of Health and Family Welfare, 2005).

Table 2 : Trends in the Health Care Infrastructure in India (1951 – 2004)

Sr. No.	Particulars	1951	1981	2005
01	SC/PHC/CHC	725	57,353	1,71,608
02	Dispensaries and Hospitals (All)	9,209	23,555	27,770
03	Beds (Private & Public)	1,17,198	5,69,495	9,14,543
04	Nursing Personnel	18,054	1,43,687	8,65,135
05	Doctors (Modern System)	61,800	2,68,700	6,56,111

Source: Ibid.

Further, one can also find significant improvement also in Health Care Infrastructure as shown in Table Number 02. One can find consistent increase in the total number of Dispensaries and Hospitals as well as Total Number of Beds in the Hospitals as well as Doctors & Nursing Staff (Ibid).

The Rural Primary Public Health Infrastructure has recorded an impressive increase consisting of 1, 45,000 Sub-Centers as well as 23,109 Primary Health Centers, and 3,222 Community Health Centers, catering to a population of 5,000, 30,000 and 1,00,000 respectively as well as 3,000, 20,000 and 80,000 Populations in Tribes & Desert Areas respectively (Annual Report of Health & Family Welfare Report, 2005-2006).

Source: www.cbhidghs.nic.in (1) GOI, 1997 (Adapted from Human Development in South Asia, 2004), & Central Bureau of Health Intelligence, Ministry of health & Family Welfare.

Public health is of crucial importance to any community and it needs to be given priority. If one considers, the Health Expenditure of India in view of prevalent trends on basis of the various Five Year Plans of India as shown in the Table number 03, it becomes evident that the priority to Health Sector of India showed declining trend in terms of Expenditure incurred on Health as a per cent of Total Development Plans of India. The amount spent on Health Sector of India in the First Year Plan (1951-1956) was 3.33 per cent that has been reduced to 2.09 per cent in the Tenth Five Year Plan in India (2002-2007).Therefore, there exist a need to enhance and broaden the Public Health Knowledge with new research activities and community based experiences.

REVIEW OF LITERATURE

An attempt has been made by the researchers to offer a comprehensive review of literature on measurement of Patients' Satisfaction as follows.

- Susan Michie, Che Rosebert (1994) described the stages involved in developing a satisfaction survey for out-patients attending a London teaching hospital, using existing expertise within the organization. Its

Table 3 : Trends in Health Expenditure of India (1951 – 2002) :(Rupees in Millions)

Five Year Plans	Period	Amount	Total Plan Investment (All Development Heads)	Health (Central & States)	
				Outlay/ Expenditure	Per cent of Total Plan
First	**1951-1956**	**Actual**	**1,960**	**652**	**3.33**
Second	1956-1961	Actual	4,672	1,408	3.01
Third	1661-1966	Actual	8,576.5	2,259	2.63
Annual	1966-1969	Actual	6,625.4	1,402	2.12
Fourth	1969-1974	Actual	15,778.8	3,355	2.13
Fifth	1974-1979	Actual	39,426.2	7,608	1.93
	1979-1980	Actual	12,176.5	2,231	1.83
Sixth	1980-1985	Outlay	97,500	1,821	1.87
Sixth	1980-1985	Actual	1,09,291.7	20,252	1.85
Seventh	1985-1990	Outlay	1,80,000	33,929	1.88
Seventh	1985-1990	Actual	2,18,729	36,886	1.69
	1990-1991	Actual	61,518	9,609	1.56
	1991-1992	Actual	65,855	10,422	1.58
Eighth	1992-1997	Outlay	4,34,100	75,822	1.75
Ninth	1997-2002	Outlay	8,59,200	19,818.4	2.31
Tenth	2002-2007	Outlay	14,84,131.3	31023.3	2.09
Eleventh	**2007-2012**	**Outlay**	**36,44 ,718**	**-**	**-**

results showed that overall, greatest dissatisfaction was expressed about the length of time spent waiting to see a doctor, one of the clinical support services and the facilities such as car parking and refreshments. Greatest satisfaction was expressed for the personal consideration shown by doctors, nurses and other clinic staff, the manner of being received at the hospital clinic and reception, and the contact with the hospital when booking the appointment (Susan Michie, Che Rosebert, 1994).

- Steven A, Taylor and J, Joseph Cronin Jr., (1994) clarified and extended the conceptualization and measurement of consumer satisfaction and service quality in health services. Although, the two constructs SERVQUAL and SERVPERF serves as cornerstones in the design and implementation of health care marketing strategies, a review of literature suggested that satisfaction and service quality are difficult to distinguish, both conceptually and operationally, in health care settings. The findings from two studies conducted by the authors to distinguish the nature of these two important constructs within a health care marketing context revealed that a non-recursive relationship between service quality and patients' satisfaction. Health services marketers should be careful about trying to apply broad theories and scales such as SERVQUAL and SERVPERF used in other service settings because they may translate poorly to health care. (Steven A, Taylor and J, Joseph Cronin Jr., 1994).
- Emilie Roberts et. al., (1994) developed a method of assessing the quality of health care to highlight the areas of greatest concern to patients designed to examine patients' experience with care starting with the concerns expressed by patients and using it as a basis for evaluating and ranking different aspects of the service which needed improvement. The paired comparison technique was successfully used and validated in a variety of commercial and business environments. The aim of this case study was to assess the feasibility of the paired comparison technique in rating patients' satisfaction with aspects of their care in a hospital. The results of the study indicated that the paired comparison technique, at least in its present form, cannot be recommended as a tool to aid understanding of patients' satisfaction. Its findings indicated that there were drawbacks in using the paired comparison technique to assess service quality in a highly specialized hospital setting dealing with an acute and potentially life threatening condition (Emilie Roberts et. al., 1994).
- Binshan Lin, Eileen Kelly, (1995) focused on how to reassert the importance of studying patients satisfaction surveys and to clarify and illuminate some of the methodological problems that provided several implications for researchers (Binshan Lin, Eileen Kelly, 1995).
- Hana Kasalova, (1995) demonstrated that the apparent generosity error that is, subjectivity in rating service quality may be compensated for by a mathematical process that is, rectification, which was derived from the assessment of every respondent's general scale. In all cases, the patients' satisfaction was found to be very high in spite of the fact that the originally used five-point scale was changed to a nine-point one in order to give respondents the chance to measure more accurately the quality of individual services. However, the generosity error intervened again: even with detailed instructions that five points would mean "good, fair quality", most questions again elicited an "excellent" (nine points) as answers. (Hana Kasalova, 1995).
- Zack Z. Cernovsky et. al., (1997) explored the relationship of treatment satisfaction to another personality questionnaire, the Zuckerman's Sensation Seeking Scales. Satisfaction of 119 addicts with an addiction treatment program was measured by an 11 item satisfaction scale. The Sensation Seeking scales included 40 items, and the patients' were asked to rate their satisfaction with psychotherapeutic interventions, psychological tests, medical laboratory tests, with hospital rules, and hospital meals and snack foods. Its results indicated overall high level of satisfaction with the programme (Zack Z. Cernovsky et. al., 1997).
- Ingemar Eckerlund et. al. (1997) conducted a pilot study at three departments of ophthalmology in Sweden and the data were collected using questionnaire involving a new method called quality, satisfaction, and performance (QSP) which was used to measure quality and to focus on quality improvement and consisted of three integrated components. First component measured the degree of patients' satisfaction, and different aspects thereof, among different patients groups. Second component measured patients' perceived quality levels of various quality dimensions, and the third component focused on goals, with questions directed at what patients' satisfaction should ultimately lead to, viz., increased trust, and increased likelihood for positive recommendations. The questionnaire addressed eight different quality dimensions viz., accessibility; hospitality; service commitment; environment; information advice; staff knowledge; participation influence, and continuity freedom of choice. It not only measured the degree of satisfaction but also the impact that various quality dimensions or factors had on patients' satisfaction apart from an advantage of validity in the model that is required for the user to specify organizational goals (Ingemar Eckerlund et. al., 1997).

- Eileen Evason, Dorothy Whittington, (1997)offered results of a focus group exercise conducted in 1993 with ten groups of people who had been in-patients, or who had children who had been in-patients, at a complex of hospital facilities in Northern Ireland, and it was found that the focus group methodology was successful in amplifying feedback previously gleaned from surveys.
- It also highlighted patients' tolerance of shortcomings and their appreciation of staff providing high quality care while under pressure. It was concluded that patients regarded the National Health Service as deteriorating generally (Eileen Evason, Dorothy Whittington, 1997).
- Reva Berman Brown, Louise Bell (1998) described the research process and the development of the instrument employed in auditing patients' perceptions of quality and also described the adaptation processes used in order to place the Parasuraman SERVQUAL instrument into the health setting in the UK. The researchers examined the issue of auditing from a new perspective that solely focused on the views of the service user. It was guided by two already-validated research instruments that is, the first model Parasuraman SERVQUAL instrument (Parasuraman et al., 1988), and second model developed by the Heywood- Farmer instrument (Heywood-Farmer and Stuart, 1990), which looked at professional service quality, and was originally used to audit the quality of service provided by General Practitioner (GPs) (Reva Berman Brown, Louise Bell, 1998).
- Clara Martinez Fuentes (1999) had developed a methodological analysis for the use of the SERVQUAL measure scale in the Spanish public health sector to focus on the analysis of the quality of the service given by public hospitals, on one hand, and on the dimensions of this service, which were appreciated by customers, on the other hand. The conceptual basis of this study centered on the quality of service in public hospitals and measured satisfaction by focusing on structure, process and result. In the literature on service quality, two models have emerged and the first model was posited by Gronroos (1982) known as the Image Model which advocated that perceived total quality will depend basically on two variables that is, what the customer already expects of the service; and the manner in which this service has been performed in its technical and functional aspects. The second model, known as the Gap Model was developed by Parasuraman et al. (1985), also from the idea that the quality of a service depends on experience and perception and it presented five kinds of gaps. By synthesizing these two models, quality in a service, in a positive sense, will exist when perceived quality exceeds the expected quality. Cronin and Taylor (1994) made most criticisms of the SERVQUAL Gap Model that measurement of quality exclusively by means of perceptions of the result is more valid than by the difference between expectations and perceptions of the result.

This scale, which they call SERVPERF, is equivalent to SERVQUAL but excluding the statements about expectations, and the weightings. To carry out the research a questionnaire defined based on the SERVQUAL was administered on 170 patients in the city of Valencia, and findings were presented in to three important measures aimed at measuring service quality which included, tangibles, reliability or technical quality and process of performance of the service or functional quality of the process (Clara Martinez Fuentes, 1999).

- Ulf Goran Ahlfors et. al. (2001) considered to develop and undertook clinical evaluation of consumer satisfaction rating scale (UKU-ConSat).Its results showed that it could be applied to several relevant patient categories viz., psychotic; affective; neurotic, organic and alcohol and substance abuse disorders. According to both patients and staff the rating scale promises to become useful both for research and for improvement of routine psychiatric services. The construction of the scale permitted both an overall assessment of patients' satisfaction and a more detailed assessment of specific ingredients of the structure and process of care and the outcome (Ulf Goran Ahlfors et. al., 2001).
- Jessie L. Tucker, Sheila R. Adams (2001) investigated the apparent methodological shortcomings of the literature that considered patients' evaluations of their care. The multidimensional aspects of satisfaction suggested by previous studies to predict satisfaction were access, communication, and outcomes. As suggested by other previous studies, the independent variables used to predict quality were caring, empathy, reliability, and responsiveness. Its results suggested that just two distinct dimensions of the care experience were found to capture 74 per cent of the variance in satisfaction-quality, with patients' socio-demographic differences accounting for only 1 per cent. These two distinct dimensions included provider performance aspects and access (Jessie L. Tucker, Sheila R. Adams, 2001).
- Thomas Meehan et. al. (2002) conducted a research study to report on the development, testing and psychometric properties of a brief consumer satisfaction measure for use with psychiatric inpatients. Focus group discussions with inpatients were used to develop a pool of items related to satisfaction with hospital stay. Instrument development employed three separate but related phases. In Phase I, focus group discussions with 66 inpatients at three acute care units with the aim to generate a pool of items related to

patients' satisfaction with hospital stay was conducted. In Phase II, a second sample of 72 patients from the same three acute units was asked to rate the 51 items in terms of importance in contributing to their satisfaction. During the Phase III, the draft questionnaire was administered on 494 consecutive inpatients that were approached to discharge in acute and rehabilitation facilities, and 356 completed surveys were returned.

Factor analysis yielded three factors comprising of a staff-patients alliance; doctor and treatment issue, and an environmental component. The in-patients' evaluation of service questionnaire addressed many of the shortcomings of existing satisfaction measures. It was developed through extensive consumer involvement, it is simply worded, easy to score and appears to perform well with acute and rehabilitation inpatients (Thomas Meehan et. al., 2002).

- Gigantesco, P Morosini, A. Bazzoni, (2003) conducted study with an objective to validate a brief self-completed questionnaire for routinely assessing patients' opinions on the quality of care in inpatients' psychiatric wards which concluded that the questionnaire seemed to be adequate for evaluating patients' opinions on care in inpatient psychiatric wards because of its user-friendliness and suitability for routine use (A. Gigantesco, P Morosini, A. Bazzoni, 2003).
- Reva Berman Brown, Louise Bell, (2005) conducted study aimed to describe the research process, and the development of the instrument was employed in auditing patients' perceptions of quality improvement in a community health care trust in a coastal town in Essex, England. The questionnaire was administered in by means of face-to-face meetings in the respondents' homes, and through the mail and 123 patients out of the sample of 210 participated in the research. The instrument had measured health outcomes in terms of quality improvement from the users' perspective, and highlighted gaps between what the service offers in terms of quality and users' perceptions of what is delivered. Factor analysis provided three factors or that included, physical surroundings; treatment by staff, and understanding of treatment.
- It offered that patient-centered quality improvement audit should be undertaken regularly so that both non-clinical managers and health care professionals can establish whether or not they are providing services that are patient-friendly and effective from the user's viewpoint or not (Reva Berman Brown, Louise Bell, 2005).

DISCUSSION

Patients' Satisfaction: An attempt has been made to reflect on various issues and its implications concerning standardization in patients' satisfaction measurement considering its three pioneering questions viz., Is patient satisfaction worth measuring? How can it best be measured? And how are we to use the results?

- **Is Patient Satisfaction Worth Measuring?**

On one side the worried alliance of consumer advocates, marketing specialists, and proponents of patient-centered care favour the activities of measuring patient satisfaction. On the other side are skeptics who believe that focusing on patients' satisfaction diverts attention from what ought to be healthcare providers principal concerns in an era of resource constraints: inappropriate care; under use of necessary care; and clinical outcomes such as morbidity, mortality, and health status. These critics argument have a point in a sense that compared with measures of technical quality, data on patient satisfaction are easy to collect, and many health care organizations have surrendered to the temptation to stop there. Nevertheless, helping patients' achieve their goals is a fundamental aim of medicine. Because patients' goals and values vary widely, and are not predictable on the basis of demographic and disease factors alone, and are subject to change, the only way to determine what patients' want and whether their needs are being met is to ask them. From this perspective, viewing care through the patient's eyes is an ethical and professional imperative. Individual clinicians, medical groups, hospitals, and health plans all have reason to be interested in patient satisfaction, and not only because satisfied customers add to the bottom line. Indeed, arguments over the place of patient ratings usually turn not on whether measuring patient satisfaction is important, but on whether satisfaction can be measured reproducibly and meaningfully (Richard Kravitz, 1998, www.ncbi.nlm.nih.gov).

- **How Can Patient Satisfaction Be Measured Best Way?**

If patient satisfaction is to take its place alongside morbidity, mortality, and functional status, several critical measurement issues must be addressed that are outlined in brief as follows.

- **Scale Development Dilemma:**

First, scale developers and end-users need to be clear about what they are measuring. Patient satisfaction is not a unitary concept but rather a refinement of perceptions and values. Perceptions are patients' beliefs about occurrences that echo what has happened. Values are the weights patients' apply to these occurrences that demonstrate their desirability, expectation, and necessity. Most contemporary measures of patient satisfaction employ hybrid questions that assess perceptions and values simultaneously. Such hybrid questions have the virtue of linguistic economy but make it difficult to distinguish perceptions from values. Given these semantic vagaries, a patient who receives poor care but has low standards may report the same satisfaction as a patient who receives good care but whose standards are unreasonably high. If in the instrument developed

patients' are asked about "Did the provider explain what to do if problems or symptoms continued, got worse, or came back?" Responses to questions of this type are not readily summed or averaged, and, nevertheless, what is lost in scalability is gained in interpretability (ibid).

- **Significance of Questionnaire Instrument in Patient Satisfaction Measurement:**

Patients' satisfaction measurement with medical care is not forthright. One approach is to use qualitative methods, but these are difficult to use for routine large scale service evaluation. Another alternative is to use a quantitative questionnaire which must be reliable, consistent, valid and with minimum errors of responses (**Robert K McKinley** et., al. 1997, http://www.bmj.com).

- **Relationship Between Patient Satisfaction, Process of Health Care & its Outcomes:**

Another issue relating to patients' satisfaction measurement is with regard to the relation between patient satisfaction, process of care, and health outcomes. The association between patients' satisfaction and health status represents a tendency for healthier patients' to report greater satisfaction, rather than a tendency for patients' whose health has improved due to medical care to report greater satisfaction (Richard Kravitz, 1998, www.ncbi.nlm.nih.gov).

- **Use of Results of the Patient Satisfaction Measurement:**

The real issue is concerning use of results of the patients' satisfaction measurement as many satisfaction batteries can reliably distinguish between physicians who are great communicators and those who are interpersonally challenged. It is also related to a variety of downstream outcomes, such as the propensity to change health plans, or to sue for malpractice. These results are clearly of interest to healthcare managers and marketers, but their relation to clinical quality improvement is weak. Separating patient perceptions from patient values and using questions that focus on potentially variable behaviors, of persons and of organizations, would help. If patient satisfaction measurement is not to be dismissed as one more health care fad, many challenges, like philosophical, empirical, and practical must still be addressed (Ibid).

- **Modification in Patients' Satisfaction Measurement Surveys:**

The variations in the patients' satisfaction measurement are an impediment to make it a reliable part of the quality equation. Even if variation of patient satisfaction measurement can be minimized to permit meaningful comparisons across providers, questions remain as to adapt to patient satisfaction surveys with appropriate modification so it can fulfill an expanded role of quality of healthcare measurement (Christopher Guadagnino, 2003).

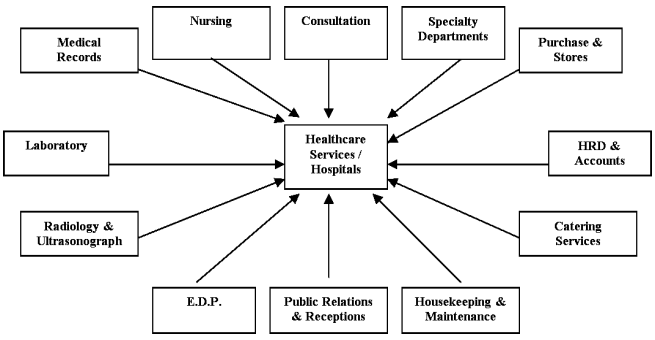
- **Lack of Comparability of Information in Patients' Satisfaction Measurement:**

Lack of comparability of patient satisfaction data, however, remains another hindrance in its expanded use. The biggest single methodological obstacle to expanding the use of surveys to targeted groups of patients is the ability to collect a large enough sample from each group to yield valid results (ibid).

A Need for Standardization in Patients' Satisfaction Measurement in Hospital Services: In a competitive world, striving for excellence in every sphere for marching towards 21st century the standardization become essential which help in getting recognition to organization's practices and procedures. With the changing trends in medicine in the healthcare sector, the increasing awareness of the patients regarding quality medical services, and quest for patient satisfaction, healthcare/hospital services providers begun to realize the advantages of adopting a systematic way of functioning through standardization. The development of quality standards can bring about uniformity and consistency in practices and documentation of systems in use in healthcare organization.

However, many officials in hospitals are still a bit nervous and skeptical, about introducing standardization activities in medical practices as they are still not convinced about impact of standardization on improving the running of hospital efficiently. But, still no one can deny the fact that the standardization helps to render better hospital services to patients as shown in Figure given as below.

Figure 2 : Area Needs Standardization in Healthcare/ Hospital Services



Source: http://mdrf-eprints.in/

To illustrate, there are plethora of laboratories in and around many hospitals giving varied results for the same sample. Being service oriented does these service providers do not have a major responsibility to ensure that the results generated by them are absolutely precise and reproducible. These standards can be developed and achieved by ensuring that equipment should be systematically inspected and regularly calibrated to obtain accurate and reliable results. periodical validation of results to avoid Inter and Intra observer variations, and avoiding breakdown costs through regular preventive maintenance supported with

compulsory calibration of all equipment and maintenance of such calibration records. Further cleanliness and hygiene must form part of quality of health care in the hospitals. Hospital-acquired infection can further aggravate the patient's difficulty. A major source of such infection is haphazard disposal of excrement, urine and other body fluid resulting in high risk of cross infections that may occur due to contact with such infectious wastes, splash of these body fluids and airborne infectious aerosols contaminating utensils, test tubes etc., that are used without proper cleaning. An efficient cleaning with high impact washing water followed by most steam heat destroys any pathogens remaining on the test tubes and other surfaces. The closed system disposal equipment that is incinerator need to be installed, and Needle tips must be incinerated through the needle burner/cutter and then packed separately, labeled and handed over to the cleaners.

Medical records are the folders which hold information regarding diagnosis and treatment. In many cases these records are not handled with the required care resulting in incomplete records, missing forms, illegible handwriting, unclear and unaccountable statements and improper filling. For this uniform methods and standards should be brought in to practice for keeping Medical Records. It is remarkable that even examination done by doctors can be standardized, thus avoiding wrong interpretation, missing diagnosis and unnecessary variation in patient care practices (http://mdrf-eprints.in). So, standardization and continuous interaction with patients shall enable healthcare service providers to solve problems of both patients and hospital service providers that would be helpful also in developing quality-oriented technologies, procedures, and systems, which can earns patients' positive word of mouth through delivery of desired patients' satisfaction that can be applied as shown in a figure given as below.. The benefits of standardization are highlighted in figure number 03 as given below.

Figure 3: Results of Standardization in Hospital Services

The Quality Diamond Model of Patient Satisfaction: Patients' satisfaction measurement is a complex task relating to hospital Services as provided by different types of hospitals which are significant from two perspectives. First, patients constitute the hospital's direct clientele. The patients' overall satisfaction is crucial aspect of the hospital service apart from other dimensions like technical quality of medical care, and effectiveness of medical treatment. Second, it provides an indirect measure of many other dimensions. It is usually correlated with effectiveness of medical treatment. The service quality of medical services too is multifaceted and its assessment requires manifold measures of process viz., response times, prescription, and admission rates combined with measures of outcome such as health status and patients' satisfaction.

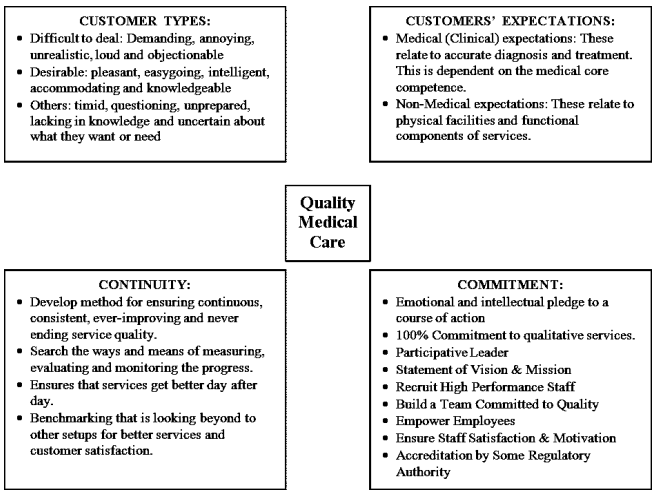
Low patient satisfaction might be a result of poor obedience of procedures, waste of resources and suboptimal clinical outcome. Thus, Patients' satisfaction should be one of the key objectives of all medical services and need be included as an outcome measure.

The continual improvement in service quality of medical services is therefore fine tuned with measurement of patients' satisfaction. Customers have general expectations form hospital services which increase the complexity in providing satisfaction to patients to have clinical core competence. It implies that cure rate does matter, and lavish physical facilities can not substitute good clinical methods; rational therapy; display of confidence, and evidence based practices Customers expect that medico professionals must honor the appointments which must be accurate and flexible supported with communication in commonly used local language instead of use of medical jargons by doctors. It is essential that doctors patiently listen to patients' problems and give them sufficient time. Customers want that doctors should display personal concern with befitting body language towards the patients, and should possibly explain the lot about their illness and treatment. The Para–Medical staff should be well-equipped with adequate health education and display concern, courtesy, promptness, responsiveness, and empathy towards patients in their behavioural patterns. They need to keep positive attitudes and should preferably be flexible in handling patients in person and in case of telephonic conversations; promptness in all responses, and emergency case, admissions etc. should be focused. Customers anticipate that they are provided with reasonably good physical facilities in both types of treatment situations that are outdoor as well as indoor, and location of the hospital should be approachable with good parking facilities, clean with adequate hygienic sanitary facilities. It should be preferably supported with child friendly environment, recreation facilities with adequate space for movements. Customers expect proper documentation with legible prescriptions; detailed discharge summary certificates, prompt issue of papers for Mediclaim, and clear explanation for administration of medicines to ensure compliance. Customers want that they should be provided with hospital information brochure and hospital should display informative sign boards. They expect transparency in financial matters, which is one of the major causes for dissatisfaction; proper display of routine consultation and indoor charges. The patients should be properly informed about the expected expenditure before any procedure or admission. Customers wish that

the hospital should make use of modern (information) technology, and adapt it with new diagnostic and therapeutic methods. The patients desire to have easy flow between various services to save time. Thus, the healthcare service providers consider factors affecting customers' expectations which include nature of medical illness; past experience in the same set up; experience at other set up; financial and social standing; level of education etc. (www.iapindia.org).

A diamond model of quality for its delivery for patients' satisfaction is given in figure as below

Figure 1 : The Quality Diamond Model of Patient Satisfaction



Source: www.iapindia.org

CONCLUDING REMARKS

Given the push toward increased provider accountability and health care quality improvement initiatives, there is no question that the attention and weight given to patient satisfaction is going to increase. Patients' satisfaction data represents real events that transpire between providers and patients, and that it needs to be seen as equivalent to clinical indicators as a parameter of quality of care. The patient is the final arbiter of what the experience of care has been, and if healthcare service provider does not pay attention to it at some level, they will not understand how their processes can be improved so that the patient can walk away with an experience that is multidimensionally okay. Satisfaction is related to the overall effectiveness of communication between physician and patient, which is necessary for achieving good outcomes, while ineffective communication can lead to poor quality. Satisfying the patient and addressing their concerns is an outcome of it as the patient is the best judge of whether their needs are being met. The changing philosophy of medicine has led to an increased sensitivity to patient satisfaction, and it focuses on quality health care, that is safe, equitable, evidence-based, timely, efficient and patient-centered healthcare services.

Hospital surveys have made physicians much more aware of patients' expectations of service quality as a separate component of quality of care. An increased focus on enhancing relationships with patients can result in a reduction in medical errors, and more satisfied patients are less likely to file medical malpractice lawsuits.

Patients' Satisfaction Survey expansion also raises the question whether patient satisfaction measurement should broaden its focus beyond quality of service and begin to measure perceptions of clinical outcomes. Some believe that patient surveys should add more specific questions about clinical quality to open a new window on provider care practices and further drive quality improvement, while others see fundamental barriers to integrating perceptions of service and clinical quality. While satisfaction measurement is still being used primarily to monitor and improve service excellence, some hospitals are beginning to ask more sophisticated, clinically-oriented patient satisfaction questions, such as whether a person felt safe during hospitalizations and whether they observed a medical error occur.

As patients become more sophisticated in their understanding of healthcare service provider, outcomes and complications rates, their perceptions of clinical quality should increasingly become part of their evaluation and satisfaction ratings.

There is going to be some movement in the healthcare industry toward asking patients more direct questions about the perceived level of the quality of care delivered, such as whether they were given the wrong medicine, whether the provider made the diagnosis accurately, and whether the patient got better.

But such a trend has limitations, that is, patient perception data about clinical processes and outcomes may lack validity, and not many tools currently exist to measure what is going on inside a hospital or a physician's office. There is also a belief that patient satisfaction measurement is best kept to the quality of service side rather than become integrated with quality of care issues. The importance and limitations of expanded patient satisfaction measurement can be expressed as "The perfect health care delivery is a perfect outcome and a perfectly happy patient" (ibid).

The very process of measuring patient satisfaction reinforces a philosophy of quality by alerting patients' satisfaction that physicians are held accountable and showing physicians that patients' are pleased with the quality of care they receive. The physician ratings tend to be the highest scores of any category on the surveys, which continues to reinforce for physicians the positive relationships they foster with patients', who in turn

encourage other patients' to seek care at same hospital. Quality improvement feedback mechanisms are more useful in addressing provider-related concerns, such as the complaint and grievance process, and provider access and availability review. Healthcare Parishioners use the surveys to retain patient populations and attract more market share, to verify patient satisfaction results, and to assess and measure specific initiatives taken by healthcare service providers.

Practices that do wish to audit patient perceptions can acquire customized surveys to identify issues specific to the nuances of their practice, to identify services that they may need to add to the practice, to reinforce areas of excellent performance and to substantiate suspected problems. Patient satisfaction data are also valuable for staff training, morale-building and creative marketing.

Patients' satisfaction measurement and interaction with patients would be unable to solve their problems and help to develop quality–oriented technologies, procedures and systems. This can reduce healthcare costs while providing customer satisfaction. A satisfied customer is an image builder of a healthcare organization/hospital. Undoubtedly, the healthcare organization/hospital not only builds its own image and good-will but also develops its services through quality standardization. The hospital thus earns customer loyalty because it aims to continuously satisfy their customers.

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