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Research Paper

PRIVATE HEALTHCARE SERVICES IN NON-METRO REGIONS

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Abstract

Healthcare seems to have dubious distinctions. Immense potential is being heralded on one side while the pathetic situation especially with respect to service quality is being magnified on the contrary. The Private sector has made advantageous moves perhaps at the cost of Public healthcare. This doctoral-level research assessed the service quality of medical services in addition to hospitality services in Private Hospitals at Kolar district, a non-metro region in Karnataka State in India.

Keywords: Private Hospitals, Service Quality, Healthcare, Non-Metro.

1. Introduction

Healthcare system in India has come a long way and has been witnessing revolutionary growth [1, 2, 3], especially, in the last decade. Some major trends are highlighted here: (i) Citizens today live in a high-tech environment with a grueling work life and hardly any time for physical recreation. The impact has been disastrous. Lifestyle diseases dominate the population rather than communicable diseases. Cholesterol and blood pressure levels are found to be high along with obesity and alcohol problems;(ii) Hospital chains are now looking beyond Tier-1 cities to spread their reach. Vaatsalya Healthcare is one such chain which is focusing on Tier-II and Tier-III cities. Government has been found to levy less tax for establishing hospitals in semi-urban and rural places; (iii) Manipal and Fortis Groups, for example, have contract with Management of Multi-National Firms and offer a service package based on requirements; (iv) Telemedicine is gaining popularity as seen as a relief to solve the urban-rural divide. It fosters inexpensive consultation and diagnosis in remote locations using state-of-the-art Telecom; (v) The urge to indulge in life insurance has seen a boom in the country; (vi) Mobile health services are gaining momentum with specialized services for women (CycleTel Humsafar); (vii) Technology is being leveraged to offer a gamut of services like PRACTO, Electronic Medical Records, Electronic Health Records, Hospital Information System and Digital Health Knowledge Resources. These help to

facilitate better service delivery and patient engagement; (viii)Hospitals have commenced mimicking Hotels and Tourism by providing helicopter services for patient pick-up and drop. Hospital rooms now have executive-style suites, dedicated personnel and security and a 5-star ambience.

2. Need for the research

In spite of the trends and growth in healthcare, there are problems galore. The issues include unnecessary diagnostics and tests, expensive medicine, incompetent service delivery, unqualified or ill-trained human capital, malfunctioning or obsolete equipment, escalating health expenses, debate about private versus public healthcare, lack of leadership (Management); ignoring obligation to provide free care to a sector of poor patients; non-compliance with regulations. Hence, need for research exists in several areas. One important area is the quality of healthcare services, especially when patients are coughing up large amounts (expenses) at the cost of ignoring healthcare provided by Government hospitals. Research has focused mainly on metropolitan cities and popular Brand names in the Private healthcare sector. This research alleviates gaps by:

(a) Focusing on Kolar district (non-urban/metro).
(b) Fostering a holistic view as it comprises analysis of medical service quality as well as hospitality service quality.
(c) Causal research which aids in studying relationships with patient satisfaction and loyalty.

3. Materials and methods

The research aimed to propose a conceptual framework and test the causal relations between perceived medical service quality, perceived hospitality service quality, patient satisfaction and patient loyalty. Causal research design was employed for the research. Patients who had undergone treatment or were undergoing treatment at Private Hospitals in Kolar district of Karnataka were surveyed with the help of a structured questionnaire. Proportionate Stratified Sampling was employed for the study wherein strata comprised two categories: Private General Hospitals / Nursing Homes and Private Multi Specialty Hospitals. Among the stratum, patients were chosen at random. The estimated and actual sample sizes were 380 and 471patients respectively. The research framework was compiled based on exhaustive review of literature and research gaps. The endogenous variables were retention loyalty; advocacy loyalty; consumption loyalty; perceived medical service quality; perceived hospitality service quality; patient satisfaction; and patient loyalty. The exogenous variables were doctor / physician; diagnostics; nursing staff; premises and employees; admissions; meals; housekeeping, and discharge.

4. Analysis and discussion

The results of the Structural Equation Modelling, used to estimate the parameters of the structural model, are presented in Figure 1.

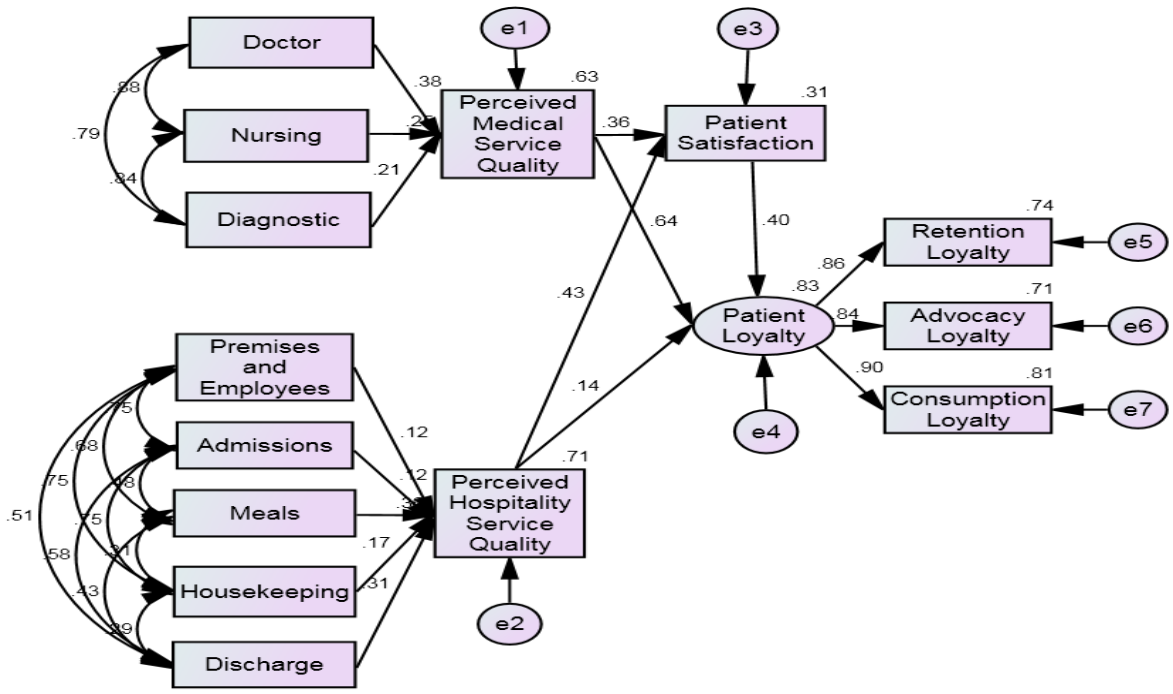
$H_{01.1}$: Doctors / Physicians have no effect on Perceived Medical Service Quality.
$H_{01.2}$: Nursing staff have no effect on Perceived Medical Service Quality.
$H_{01.3}$: Diagnostics have no effect on Perceived Medical Service Quality.

The positive coefficient implies that for every 0.379 unit-increase in Doctors / Physicians, there will be 1 unit-increase in Perceived Medical Service Quality. The positive coefficient implies that for every

0.247 unit-increase in nursing staff, there will be 1 unit-increase in Perceived Medical Service Quality. The positive coefficient implies that for every 0.213 unit-increase in Diagnostics, there will be 1 unit-increase in Perceived Medical Service Quality.

Figure 1

SEM Path Analysis



$H_{02.1}$: Premises and Employees have no effect on Perceived Hospitality *Service Quality.*
$H_{02.2}$: Admissions have no effect on Perceived Hospitality *Service Quality.*
$H_{02.3}$: Meals *have no effect on Perceived* Hospitality *Service Quality.*
$H_{02.4}$: Housekeeping have no effect on Perceived Hospitality *Service Quality.*
$H_{02.5}$: Discharge have no effect on Perceived Hospitality *Service Quality.*

The positive coefficient implies that for every 0.121 unit-increase in Premises and Employees, there will be 1 unit-increase in Perceived Hospitality Service Quality. The positive coefficient implies that for every 0.124 unit-increase in Admissions, there will be 1 unit-increase in Perceived Hospitality Service Quality. The positive coefficient implies that for every 0.355 unit-increase in Meals, there will be 1 unit-increase in Perceived Hospitality Service Quality. The positive coefficient implies that for every 0.166 unit-increase in Housekeeping, there will be 1 unit-increase in Perceived Hospitality Service Quality. The positive coefficient implies that for every 0.314 unit-increase in Discharge, there will be 1 unit-increase in Perceived Hospitality Service Quality.

$H_{03.1}$: Perceived Medical Service Quality have no effect on Patient Satisfaction.
$H_{03.2}$: Perceived Hospitality Service Quality have no effect on Patient Satisfaction.

The positive coefficient implies that for every 0.364 unit-increase in Perceived Medical Service Quality, there will be 1 unit-increase in Patient Satisfaction. The positive coefficient implies that for every 0.427 unit-increase in Perceived Hospitality Service Quality, there will be 1 unit-increase in Patient Satisfaction.

$H_{04.1}$: Patient satisfaction has no effect on Patient Loyalty.
$H_{04.2}$: Perceived Medical Service Quality have no effect on Patient Loyalty.
$H_{04.3}$: Perceived Hospitality Service Quality have no effect on Patient Loyalty.

The positive coefficient implies that for every 0.402 unit-increase in Patient satisfaction, there will be 1 unit-increase in Patient Loyalty. The positive coefficient implies that for every 0.64 unit-increase in Perceived Medical Service Quality, there will be 1 unit-increase in Patient Loyalty. The positive coefficient implies that for every 0.142 unit-increase in Perceived Hospitality Service Quality, there will be 1 unit-increase in Patient Loyalty.

$H_{05.1}$: Retention Loyalty has no effect on Patient Loyalty.
$H_{05.2}$: Advocacy Loyalty have no effect on Patient Loyalty.
$H_{05.3}$: Consumption Loyalty have no effect on Patient Loyalty.

The positive coefficient implies that for every 0.859 unit-increase in Retention Loyalty, there will be 1 unit-increase in Patient Loyalty. The positive coefficient implies that for every 0.841 unit-increase in Advocacy Loyalty, there will be 1 unit-increase in Patient Loyalty. The positive coefficient implies that for every 0.902 unit-increase in Consumption Loyalty, there will be 1 unit-increase in Patient Loyalty.

5. Conclusion

Doctors/Physicians, nursing staff and diagnostics have a positive impact on perceived medical service quality. Premises and employees, admissions, meals, housekeeping and discharge have a positive impact on perceived hospitality service quality. Perceived medical and hospitality service quality have a positive impact on patient satisfaction and loyalty. Patient loyalty is positively influenced by retention, advocacy and consumption loyalty.

6. References

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