CHAPTER II

LITERATURE REVIEW

THE STRATEGIC MANAGEMENT OF THE UNIVERSITY HOSPITAL

Assessing the Environment of the University Hospital

Environmental analysis is the process of monitoring the organizational environment to identify both present and future threats and opportunities that may influence the organization's ability to reach its goals. The organizational environment is the set of all factors both outside and inside the organization that can affect its process toward attaining those goals. According to Naylor (1985) the organization strategic planner for General Motors, awareness of the organizational environment is vital to an organization's success. Accordingly, management should constantly gather and consider the implications of data related to important environmental factors (Samuel and Paul, 1990).

Although the circumstances of each UH are to some extent unique, certain future trends appear to be widely agree upon. A model developed by Porter (1975) and adapted to the hospital industry by Autry and Thomas (1986), assumes that the health care industry will become more competitive in the future and that UHs will need to compete in order to meet their missions effectively.

Howard, Thomas, A. and Thomas, E. (1990) developed a model for analyzing the impact of environmental changes on UHs. Their key environment factors likely to influence the performance of UHs are: demographics, technology, finance, human resources, and government. They

focus on these five environmental factors because the factors involve resources that are necessary for UHs to meet their missions. Specifically, the demographic factor concerns the changing characteristics and needs (e.g. aging) of individuals in UH service areas. Technology, finances, and human resources are needed to produce UH services. Finally, state and federal governments play a large role in regulating and financing UH activities.

For analyzing an organization's overall situation, SWOT analysis is an useful tool (Samuel and Paul, 1990). (SWOT stands for strengths, weaknesses, opportunities, and threats). This approach attempts to balance the internal strengths and weaknesses of organization with the opportunities and threats that their external environment present. This approach suggests that the major issues facing an organization can be isolated through careful analysis of each of these four elements. Strategies can then be formulated to address these issues.

To assess the external environment, the UHs should identify the opportunities and threats their faces. Opportunities and threats can be discovered by monitoring a variety of political, economic, social, and technological (PEST) forces and trends. PEST is an appropriate acronym for these forces and trends because organizations typically must change in response to them, and the change can be quite painful (Bryson, 1988).

To assess the internal environment means that UHs have to identify internal strengths and weaknesses, they might monitor resources (inputs), present strategy (process), and performance (outputs). Most organizations have volumes of information on their inputs. They tend to have a less clear idea of their present strategy, either overall or by function. And typically they can say little, if anything, about outputs, let alone the effects those outputs have on clients, customers, or payers (Bryson,

1988).

Missions of the University Hospital

Organizational mission is the purpose for which, or reason why, an organization exists (Samnel and Paul, 1990). In a fundamental sense, the mission of UHs continues to be (Smith, 1988):

- To train future generations of health professionals,
- To advance understanding of human biology and health service delivery, and
- To provide exemplary health care services.

This central mission consists of high-quality care and teaching conducted in an atmosphere of social concern and scholarly inquiry into the nature, causation, prevention, and therapy of human disease. In UHs, the responsibility to teach and do research in the laboratory, at the bedside, and in the community enhances the fundamental goal of entirely personal compassionate patient care. UHs strive to provide superlative patient care, considered to be the requisite model for learning. The educational process aims to graduate individuals who will be committed to a lifetime of continuing education while they are contributing in many and varied way to the health needs of people.

To respond to the circumstances they are facing, UH services should not be seen as an end in themselves, but must justify their existence based on how well they meet the social and political needs of their various stakeholders. UH strategic planning must be rooted in both mission and in public need. Unless missions reflect the needs of communities, however defined, the resources will not be available to achieve them. Once missions and public needs are reconciled, then UHs can

proceed with evaluating alternative means for fulfilling their goals (Smith, 1988).

Three traditional commitments of UHs are patient care, teaching, and research. However, it is important to point out that many of the strategies examined by previous researchers have as their goal making UHs more competitive as centers for patient care (Howard, Thomas, A. and Thomas, E., 1990). There are two reasons why UHs are especially concerned with patients care, although it is only one part of their mission. First, there is a high degree of interdependence among the three goals of UHs. Without an adequate mix of patients, teaching and research activities suffer. Thus, UHs see their whole mission threatened by increased competition in patient care. Second, revenues from research are difficult to increase, and financial support for medical education has decreased. As a result, UHs seem to be relying increasingly on patient care as an important source of revenue.

While UHs have provided both in-patient and out-patient services, the primary focus has been on inpatient care. New mission statements emphasize delivery of care in the most appropriate setting and acknowledge that it is necessary to be involved across the spectrum of care, including services in the home, clinic, out-patient diagnostic and treatment centers, acute hospital, and long-term care (Smith, 1988).

Hopper (1990) developed an out-patient department mission statement: "to provide the highest quality out-patient service to the patients of East Birmingham Hospital within the resources available. High quality services are appropriate, efficient and effective, and are delivered through a partnership between clinical staff, support staff, managers and patients. The provision of relevant, accurate and timely information is a key to effective service provision. Specific objectives

of the out-patient department are:

1. To facilitate specialist medical consultations, provide diagnostic and treatment procedures, and to advise patients, their cares and general practitioners.
2. To recognize every patient attending the Department as a unique person with their own personality, cultural background, social responsibilities and physical and/or psychological problems. These facets together make up an individual, who is entitled to the highest standards of appropriate multi-disciplinary care to promote and maintain all aspects of his/her well-being.
3. To fully involve the patients in the giving and evaluation of care, enabling them to leave the Department with the knowledge and confidence to enhance/resume their precious lifestyle or adapt to new circumstances.
4. To expand knowledge and to enhance the practice and the environment of care by encouraging innovation and learning at every level.
5. To promote an atmosphere conducive to good performance by encouraging shared ownership and responsibility for quality assurance, and by monitoring and evaluating locally supported service quality standards."

Stakeholder Diagnosis and Management for University Hospital

If hospital managers are to cope with the environmental turbulence and uncertainty facing hospitals, they must effectively manage their stakeholders (Blair, Savage and Whitehead, 1988).

The concept of organization stakeholders is becoming increasingly important to the analysis of the forces affecting organizations and their managers (Mason and Mitroff, 1981; Freeman, 1984; Blair, et al. 1986). Stakeholders are those individuals, groups, and organizations who have an interest in the actions of an organization and the ability to influence it (Mason and Mitroff, 1981; Carper and Litschert, 1983). They can be identified by assessing their potential for cooperation and their potential for threat to the organization (Freeman, 1984). Because hospitals are affected by stakeholders through policy and action, they must become better able to manage their relationships with relevant stakeholders. Attention to stakeholder concerns is crucial because the key to success in public and nonprofit organizations is the satisfaction of key stakeholders (Bryson, 1988).

Hospital stakeholders can be categorized into three groups --- internal, interface, and external. Internal stakeholders for example, include staff employees as well as clinic managers; external stakeholders include suppliers, patients, and financial community. The relationship between the organization and these external stakeholders is a symbiotic one because the organization depends on these stakeholders for its survival. Interface stakeholders are those who function both internally and externally to the organization -- that is, those who are on the interface between the organization and its environment. The major categories of interface stakeholders include the medical staff, the hospital board of trustees, and the corporate officers of the parent company. Each of these stakeholders has expectations for the hospital and its managers and can oppose or support any of its actions (Fottler, 1987; Blair and Whitehead, 1988).

The number of stakeholders and their influence on hospital executives is increasing. For example, patients as consumers were passive stakeholders until this decade. Low competition and relatively abundant resources allowed physicians to make most of the key decisions regarding patient care. Now the consumer is a major stakeholder, and marketing programs are directed at the individual consumer, employer, and physician. Physician medical staff members of the hospital can be categorized as one of the groups of stakeholders who have the highest potential for both threat and cooperation. This potential is primarily realized through the power that the medical staff has in referrals, the hospital would not be able to survive (Blair, Slaton and Savage, 1990).

Organizations in the health care industry have to rethink their strategies and operations as they face increasingly conflicting demands from internal, external and interface stakeholders (Flood and Scott, 1978). To manage stakeholders, health care managers must be involved in a continuous process of internal and external scanning when making strategic decisions. They must go to the traditional issues in strategic management. They must also look for those external, internal, and interface stakeholders who are likely to influence the hospital's decisions. Managers must then make two critical assessments about these stakeholders: (1) their potential to threaten the organization and (2) their potential to cooperate with it (Freeman, 1984).

DETERMINANTS OF PATIENT SATISFACTION

Emphasis on patient satisfaction with medical care is increasing, as evidenced by the greater number of empirical and theoretical publications regarding satisfaction in recent years. This emphasis is consistent with a trend toward holding providers more

accountable to their patients. Patient satisfaction with services is an important component of satisfaction with life. Thus, services that appears to be of high quality by clinical economic, or other provider-oriented criteria is far from ideal if the patient is dissatisfied (James, 1987).

The following issues, were raised by Clear and McNeil (1988):

1. Patient satisfaction with service is an important consideration in the quality of patient care and, therefore, of interest to health services researchers.
2. For policymakers, "It is necessary to identify the specific ways in which information about patient satisfaction can be used.' Two main criteria were presented for evaluating the relevance of satisfaction data to the organization and delivery of health services. 'First, it should be demonstrated that patient satisfaction is influenced by features of the organization that can be manipulated by policy changes. Second, satisfaction should be shown to be related to subsequent patient behavior.'
3. Good communication and attentiveness to patient concerns appear to be the strongest predictors of how patients will evaluate the care received.

Customer satisfaction is a popular theme of managers attempting to reshape employee attitudes to meet increasing demands by the public for responsive, courteous, and competent service. While customer service is not a new idea, there is growing recognition that customers' perceptions of the quality of service received will influence their choices of service providers. Consumer satisfaction is central to the strategy of marketing-oriented organizations. Once relegated for consideration after

service was delivered, customer satisfaction is now an integral factor in achieving a successful business outcome. Managers are focusing on patient satisfaction for achieving customer service through enhanced employee attitudes and behaviors.

The U.S. hospital industry is experiencing a consumer movement of better educated, more demanding, less easily satisfied patients. It is a rare hospital that has not planned or started a program to increase patients' satisfaction with their contact with both professional and nonprofessional staff. There can be little doubt that the successful hospital of the future will train its employees equally well in both the technical aspects and the art of patient care. Hospital managers must create the conditions for optimal customer satisfaction with services delivery. Managers need to know models and principles to build the foundation for programs that raise levels of quality and satisfaction (Speeding, Mcdermott, and Eichhorn et al. 1987).

Previous research indicated that individuals are able to differentiate between several aspects or dimensions of their care (Ware, Snyder, and Wright et al. 1975). These include, among others, general or global satisfaction; satisfaction with the cost, convenience, and availability of care; satisfaction with the technical qualities of care or professional competence of the provider; satisfaction with the art of care or personal qualities of the provider; satisfaction with the continuity of care; and satisfaction with communication and information received from the provider. Many of these dimensions are interrelated; for example, general satisfaction trends to be moderately highly correlated with each of the specific satisfaction dimensions (Doyle and Ware, 1975).

The issue of waiting time in out-patient departments is identified as an important patient satisfaction attribute by Seamus and Michael (1991), who determined that satisfaction varied according to whether patients waited longer than their planned appointment time. From the research, it was found nearly two-thirds of the patients responding waited more than half an hour beyond their planned appointment time and most of them felt dissatisfaction as a result. The Management Executive (EL 1989) stressed the importance of providing individual appointment times on which patients can rely and that long waiting times in out-patient departments are unacceptable.

The relationship between patients and medical staff is another main factors which influences patient satisfaction. In a study conducted by Korsch, Gozzi, and Francis (1968), that satisfaction was significantly higher if physicians were friendly and the patient's expectations about treatment and information were fulfilled. Larsen and Rootman (1976) also suggested an inherent link between a physician's role performance and patient satisfaction. Kincey, Bradshaw and Ley (1975) subsequently showed that satisfaction with the information conveyed by the physician is significantly associated with patient compliance. Weiss (1989) explored the relationship issue and concluded that, "the greater the degree of relationship between the physician and patient, the higher the level of patient satisfaction." Communication with the physician, has been identified as a critical issue of patient satisfaction for which treatment decisions depend heavily on patient preferences as well as on technical judgements by the physician (Cassileth, Zupkis and Sutton-Smith, 1980). Although the technical quality of care provided is extremely important, the personal quality of the physician-patient relationship seems to be a crucial ingredient in a successful care program (McCusker, 1984).

A study by the Royal Commission on the National Health Service (1978) showed that there were varying proportions of patient dissatisfied with most of the examined aspects of outpatient service. It could be seen that the most frequent complaints from out-patients dissatisfied with the service, were that they were the insufficient communication with physicians and longer waiting time.

PATIENT SATISFACTION SURVEY AND SCALE

In medicine, as in other service- or goods-producing industries, increased emphasis is being directed toward judging quality based on consumer feedback (Graham, 1987; Marr, 1986; McMillan, 1987; Coddington and Moore 1987; Garvin, 1988). Donabedian (1988a) has recently written that information about patient satisfaction should be as indispensable to assessments of quality as to the design and management of health care systems.

The use of patient satisfaction surveys has increased in the health care marketplace, due in part to the belief that the perception of quality is an important factor in the demand for services and that survey results may have a significant effect on provider behaviors (Nelson and Nicderberger, 1990).

From a business point of view, patient satisfaction studies have been designed for two purposes: (1) to employ satisfaction as a dependent variable to evaluate provider services and facilities in the belief that patient satisfaction is an indicator of the structure, process, and outcome of care; or (2) to employ satisfaction as an independent variable to predict behavior or use of services, based on the assumption that satisfaction influences patients' health care decisions (McMillan, 1987).

Other service industries have demonstrated how customer behavior promotes satisfaction. Having something to do while waiting for services both makes the wait seem shorter and promotes the sense that service has already begun. Customers who are overly demanding and tell servers how to do their jobs are promoting their own dissatisfaction. By contrast, customers who make supporting comments to servers end up more satisfied. Customers who examine the layout, see how services are produced, and make choices based on available options and costs have been shown to be more satisfied. Customers who voice any complaints they have and give providers a chance to respond may end up more satisfied than those who had no complaints, and far more satisfied than dissatisfied customers who fail to mention their complaints. In health care, patients who express their expectations and wishes to their physicians have been shown to be more satisfied as a result. Patients who negotiated the problems to be addressed are more satisfied than those who are passively diagnosed and treated. Patients who participate in addressing their own needs report higher satisfaction (Wallace, 1986).

Yet the actual value of patient satisfaction studies as part of a total quality measurement process is disputed in both academic literature and the practice of medicine. Where they are used, little is known about their actual effect on the organization and delivery of health services (Nelson and Niederberger, 1990).

Working for patients stresses the importance of health authorities being responsive to the views of their customers, and regular testing of consumers' opinions is recommended by the Management Executive (EL, 89) with special reference to out-patient departments. Various techniques of assessing and measuring the customers views are available and interest in this field of enquiry seems to be continually growing. Mark, Michael and Ben, (1990) analyzed the pros and cons of customer

satisfaction surveys and indicated that the most attractive aspect of any survey of customers is that it deals direct with the user of a service and the evidence obtained carries more authority than other indirect methods of assessing of the enquiry in the sense that it seeks customers views pro-actively rather than relying passively on the retrospective analysis of complaints or compliments.

Although the data from surveys apparently reflect the customers view it should always be recognized each enquiry method has inherent flaws. By definition satisfaction is a subjective matter and is closely related to expectation. for example, in deprived areas where customers traditionally may have relatively low expectations, surveys which seek their opinions can produce an artificially high score. A factor which is often unrecognized in survey work is the volume of investment in terms of time as well as material which it requires. To do the job properly needs planning, careful instrument design and, very important, testing and revision of the instrument if necessary, as well as the administration of the findings (Learmonth, Pryce-Jones and Totterdell, 1990).

Measures of patient satisfaction are frequently used by health service researchers in the study of out-patient utilization of medical services. Such measures are used to reflect upon some outcome of the medical care process such as: the "success" of health care encounters (Blum, 1974; Cartwright, 1978; Mckinlay, 1973), consumer rating of quality (Andersen, 1971; Kelman, 1976), or the quality of doctor-patient communication (Daly and Hulka, 1975).

Hospital Patient Questionnaire is a 82 item instrument, including 80 multiple-choice questions about various aspects of the hospital service and two open-ended questions (Paul, Eleanor, Hal, et al. 1981). It is divided into eight sub-scales which evaluate individual areas of

service. Included are questions about care provided by six different sections: Nursing, Medical staff, Radiology, Laboratory, Environmental Services, and Miscellaneous Services. The Coefficient Alpha (CA) index of reliability was computed for each sub-scale (Nunnally, 1967). Coefficients ranged from .66 to .91. indicating a positive relationship between items within the sub-scales.

The measure of patient satisfaction by McCusker (1984) consists of 42 items with scale values derived via the scale product method. Its questions were divided into: general satisfaction; availability of care; continuity of care; physician availability; physician competence; personal qualities of physician; and communication with physician. Subjects were asked to indicate their level of agreement on the basis of a 5-point Likert-type scale of alternatives: (1) strongly disagree, (2) disagree, (3) undecided, (4) agree, (5) strongly agree. Cronbach's alpha was computed for each scale in each sample. They ranged from .41 -.75.

The estimate of the reliability of patient satisfaction was determined by internal consistency (Paul, Elea, Hal, et al. 1981). The reliability coefficient of .94 for the total scale indicates a more than adequate consistency of measurement for the instrument. The sub-scales Coefficient Alpha indexes of reliability are: Nursing .66; physician .88; radiology .91; laboratory .88; From McCusker's (1984) study, the internal coefficiencies of the scales were: general satisfaction, .75; personal qualities of physician, .69; and communication with physicians, .58.

QUALITATIVE RESEARCH METHOD

Over the past few decades, a noticeable increase has occurred in the utilization of research and analysis as inputs to strategic management

in health care systems. It is commonly agreed that qualitative research methodologies have much to contribute to strategic issue identification (Sumtaree K., 1981). The important facets of qualitative methodologies that contribute towards strategic management in hospitals can be summarized as follows:

(1) They are holistic and multidimensional. An anthropological method aims to grasp and portray socio-cultural conditions and envisage problems or objectives holistically. Hence, this approach can lead administrators to a better understanding of reality and contribute to realistic problem solving.

(2) They are in-depth and longitudinal. They provide detailed information, and frequently display sequential and causal relations of attributes. They, thus, give insights to administrators and policy makers into relations among various social variables.

(3) They are naturalistic. They provide observations of natural settings, natural behavior and natural treatment. Qualitative research finding are relevant to the "real world".

(4) They are humanistic. The methodologies allow the researcher to obtain first-hand knowledge about the world. He gets close to the data, and thereby, develops analytical, conceptual and humanist understanding of the situation.

(5) They are descriptive. By the narration of field notes, a reader feels he is in the field. The report, thus, gives an inner understanding of human behavior which enables administrators and policy makers to comprehend social relations in greater depth.

In brief, the five facets of qualitative methodologies allow the research to be close to the issues and to integrate themselves with the problems. They permit researchers to hypothesize as many variables as needed, to collect data as scrutinized as possible (with the help of various techniques), and to interpret information as comprehensively as is credible. In doing so, administrators and policy makers are provided with well-rounded data of social problems and deep understandings of their context. Certainly, this can help provide better alternatives for their decision making.

Open-ended questions have no answer choices from which respondents select their response. Instead, the respondents must "create" their own answers and state them in their own words. The advantages of open-ended questions are that they: stimulate free thought, solicit suggestions, probe people's memories, clarify positions. This is indispensable for exploratory studies in which a researcher's main purpose is to find the most salient aspects of a topic, perhaps in preparation for developing close-ended questions for a later survey (Woodward and Chamber, 1983).

The specific advantages of the qualitative approach over conventional questionnaires are that the causes both positive and negative, can be pinpointed, and that it is the issues seen as important by the subject which are raised, not those believed to be important by the designer of the questionnaire. Subsidiary advantages are that subjects are not required to respond mechanistically to questions on which they may have no interest or opinion and that the act of being interviewed and encouraged to speak freely is in itself seen as evidence of a true wish to obtain the subjects views rather than "just going through the motions". The use of qualitative methods can show managers how existing practices, behavior and environment are viewed by the subjects and will often clearly

indicate action which should generally improve the situation of the organization. (Pryce-Jones, 1988).

The research which uses interview guidelines containing open-ended questions are designed to direct the conversation between the researcher and subjects, but not dictate the subject's responses. The techniques of qualitative methods allow researchers to obtain deeper and more detailed information on a specific problem than do observational or quantitative studies. Since the interview context is a free-flowing discussion, the subjects are encouraged to talk freely to the interviewer and to relate any incident which caused them to form a view of the service. They can talk on many potentially relevant topics which the researcher might not have considered. Likewise, researchers can ask more in-depth questions as new information is given. Researchers are able to control the directions and relevancy of the topics discussed to a larger extent (Wathinee, 1989).