Service Quality in Health Care

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Although US health care is described as "the world's largest service industry," the quality of service—that is, the characteristics that shape the experience of care beyond technical competence—is rarely discussed in the medical literature. This article illustrates service quality principles by analyzing a routine encounter in health care from a service quality point of view. This illustration and a review of related literature from both inside and outside health care has led to the following 2 premises: First, if high-quality service had a greater presence in our practices and institutions, it would improve clinical outcomes and patient and physician satisfaction while reducing cost, and it would create competitive advantage for those who are expert in its application. Second, many other industries in the service sector have taken service quality to a high level, their techniques are readily transferable to health care, and physicians caring for patients can learn from them.

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THE HEALTH CARE SYSTEM OF THE UNITED STATES excels in its capacity to treat serious illness. Yet, American health care is troubled. Physician satisfaction,[1] respect for physicians,[2] and trust in our health system[3] are declining. In 1994 opinion polls, 75% of Americans said that our health care system required fundamental change,[4] and 84% said there was a crisis in health care.[5]

Why has this erosion occurred? Obvious causes include the fear of managed care, anxiety over the availability of health insurance, and accelerating costs. Another serious issue also plays a role, although it is less highlighted in the lay press and rarely discussed in our literature, namely, the poor quality of service in health care.

We rely on technical results as evidence of high quality, but quality has another dimension, service. By *service*, we mean the myriad characteristics that shape the experience of care for patients and their loved ones other than the technical quality of diagnostic and therapeutic procedures. Correct medications and suture placements are issues of technical quality. Promptly answering questions to the patient's satisfaction in a clear, culturally relevant, easily understood manner is service quality. Relieving pain with morphine by the right dose and route is a matter of technical quality. Doing so in a fashion that the patient feels is timely, while helping to relieve the fear of pain, is service quality.

Most patients do not feel qualified to judge technical quality but assess their health care by other dimensions that reflect what they personally value.[6] We do the same when we fly. We know flying is safe and assume we will receive high technical quality—expertly designed and maintained airplanes flown by well-trained professionals who can safely take off, fly, and land under the most trying circumstances. We measure the quality of our flight by more personal criteria—does the airline deliver what we value in terms of reliability and comfort with helpful, friendly personnel. Service means results we can see, feel, understand, and personally value. The same definition applies to service for patients. They believe most interventions are safe and assume they will receive technical expertise but measure quality based on what they understand and value.[7]

Our patients want high-quality service and do not believe they receive it.[8,9] Service characteristics are an important determinant of patient loyalty in an increasingly competitive marketplace.[10] More health care "report cards" are incorporating patient reports of service quality into publicly released ratings. Yet, despite these motivations, service quality in health care is poorly understood and insufficiently explored.[11] We do not imply that America's emphasis on technical quality is misplaced. We do believe, however, service quality deserves a much higher presence in health care.

So where do we start? We need not reinvent the wheel; others know a great deal about service quality and we can learn from them. In the global marketplace, improvement of service is not optional; it is a matter of survival. If banks, airlines, maintenance companies, financial services, package delivery firms, and hotels treated their customers to the levels of waiting, unanswered questions, inconvenience, and obscure instruction that are the norm in health care, they would be unable to survive. Rather than discuss the methods behind world-class service as abstractions, let us follow a simple health care encounter—a real one, experienced by 1 of us (J.W.K.)—and analyze it from the viewpoint of service quality.

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THE SCENARIO

I have chronic microscopic hematuria, and my new primary care physician suggested I have a follow-up intravenous pyelogram (IVP). "Simple enough," I thought. She authorized the IVP at a local, well-known medical center and told me to schedule the appointment myself. Thus, the saga began.

The prominent Yellow Pages advertisement for this renowned institution listed many numbers, none of which seemed correct. I therefore called the main hospital number and was greeted by a recording, informing me that I had called a world-class medical center. The same message was then repeated in Spanish, and the electronic receptionist asked me twice, once in Spanish and once in English, in what language I wanted the rest of the message. I chose English and was given options I could choose by telephone. None of these seemed appropriate, and so I pressed the button connecting me, at last, to a live operator.

We said the first principle of service quality management, translated into health care, is to provide results that patients value. Patients value easy access to outpatient care. Traveling to a tertiary care center on the other side of town is not easy. Searching the Yellow Pages fruitlessly for the right number is frustrating. So is listening to a long string of redundant, complex, and ultimately inadequate automated choices on a telephone. Organizations requiring these aimless journeys fail to see their systems the way patients see them and have left the road of service quality without ever getting started.

When I reached a live operator, I asked to schedule an IVP. The answer was, "What's that?" Luckily, I could explain that an IVP is an outpatient x-ray examination of my kidneys. She transferred me to another line. After 13 unanswered rings, I hung up.

The initial direct interactions with patients tend to strongly shape the experiences and emotions that follow. When this initial moment of truth goes well, a positive cycle begins between the customer and the organization; when it goes poorly, it may be difficult to recover. In many health care settings, the initial point of contact is 1 of the least supported and most thoughtlessly designed. Outpatient procedures are important to hospitals; capably managing that first telephone encounter is a key moment of truth.[12]

My moment of truth left me aggravated and frustrated. Six months passed before guilt and anxiety led me to schedule the IVP. I knew the ropes and was able to navigate more quickly the phone system to the radiology scheduling line, this time answered promptly. I asked for an appointment for my IVP and was told, "Patients cannot schedule their own exams." I protested but to no avail. The "proper procedure" was for my doctor's office to schedule the exam. When I suggested that my doctor had no information whatsoever about my schedule, I was greeted by a silence strongly implying, "So what?"

Several comments are elicited by this exchange. First, for those who question the significance of service in terms of health care outcomes, consider the result if the patient's hematuria had been secondary to a bladder or renal cell malignancy. How many treatment delays and poor outcomes are engendered by a patient's reluctance to engage a confusing, inert system?

Second, the patient has the information needed to make an appointment, but discouraged once, he is again rebuffed by a rule requiring illogical and costly rework. Quality service drives profit for great service organizations through "the 3 Rs"—retention, related services, and referrals.[13] This system seems more oriented to rejection than to retention. Retaining patients means never facing the hazards and expense of the initial moment of truth again. Retained patients will utilize related services many times in the future, thus making the "lifetime value"[13(pp60-65)] of the patient much greater than the value of the initial encounter. Finally, satisfied patients tell their friends and family, driving more referrals by word of mouth. Word of mouth is probably the most powerful force in health care marketing, as consumers want to know how others like them evaluate care. Many trust the evaluations of family members and friends more than any other source of data, including expert opinion.[14]

Third, consider the inability of the patient to schedule his own appointment. We all value control and choice. Great service increases control and choice (consider Internet airline and hotel reservations, for example). Clinicians and the organizations they work with decrease it.

We have buried choice under a mountain of wasteful superstructure designed for the benefit of clinicians and institutions, not the patient. Looking through the patient's eyes, simplifying the processes of care, and increasing choice would allow us to dismantle this superstructure and eliminate the unnecessary policies, procedures, bureaucracy, and cost it breeds.

So, I called my physician's office. The receptionist could not schedule my IVP; it was necessary for me to talk to my doctor, only available to take calls between 1 and 2 PM. I eventually made the call, and after waiting at a pay phone on hold for 5 minutes, I reached my physician. She was most accommodating. I gave her several dates, and she told me she would get back to me. At home a message was waiting, giving me a date 2 weeks in the future. I was instructed to return to her office and pick up my new authorization, which I did by making a special trip several days later.

Whose time is important? Neither the patient's, doctor's, nor staff's in this example. Although recently we in health care have made advances,[15] world-class service in other industries has been reducing waits and delays for years.[16] Top health care service would increase the speed and efficiency of support processes (like scheduling) so that skilled professionals would be more available to interact with patients and not have to waste time fighting viscous and complex systems.

The day of the exam arrived. My wife drove me to the medical center, but we misread our city map and arrived 10 minutes late. No signs at the hospital directed us to parking for outpatient services, although the sign for valet parking was clearly in view. I made a stab at going through the emergency entrance, while my wife found a place to park. I found no sign to lead me to an information desk, but I wandered to an appropriate-appearing desk, where a very pleasant woman promptly directed me to the elevators that led to

the IVP suite. I arrived at the unit, which was clearly marked in large letters: Mammography.

The biggest lessons often begin at the front door. Great service companies not only make it easy to access service; they create "channels" that no one could miss. Amenities, like valet parking, can be nearly irrelevant when the basics are not in place. The patient's need was basic. How easy or hard will it be for him to find his destination quickly and with certainty? Amenities coupled with great service can be pleasing. Amenities in the context of poor basic service can feel insulting and silly.

I apologized to the receptionist for being late and putting her unit off schedule. She told me, very pleasantly, not to worry. " Just give me your blue card," she said, "and we'll get you started." "What blue card?" "Oh, your registration card." "I don't have one." "You need to get one." My heart sank. I tried my own service recovery, "Why not do my exam first, so that you (and I) can keep to our schedule? I'll register afterward." The receptionist answered pleasantly but firmly, " I can't do that. Take 2 long lefts down this corridor, go up to the second floor, turn right, and you will be at registration." I suspected she had done this before.

Two defects: complexity (the blue card) that could long ago been engineered out of the system and the incapability of a frontline worker to do what makes sense for everyone. Great service organizations hire capable people and invest heavily in training that prepares their employees to have autonomy at the front line. This seems rarely the case in health care. The inability to deliver valued results to customers is often the No. 1 source of frustration to frontline service employees in our industry as well as others.[17-19] She is nice and probably capable, but she has no options.

This is a service recovery opportunity, a chance for an on-the-spot response when service fails.[20] Service recovery triggers concerted, immediate, and satisfying remedies when a defect occurs. These strategies must be anticipated, and the front line must have the capability and autonomy to invoke them without being second-guessed. Excellent recovery may make customers more loyal than before the defect occurred. Finally, unlike health care where medical error remains a huge problem,[21] defects are treasured as opportunities to improve, supported by data systems that identify and analyze episodes of defect and recovery to guide redesign of procedures and systems to make error in the future less likely.[22,23]

Off I went. I was able to follow her directions, even though there was no signage to direct me to the registration desk. The clerk at the registration desk seemed to regard me as an interruption. She continued to carry on a conversation with her counterpart behind her, ignoring me except to ask a question. I did get my blue card. My name was misspelled.

Not everyone can work well in a service-oriented culture. According to Hal Rosenbluth, chief executive officer of Rosenbluth International, a fast-growing, $2-billion corporate travel agency, "It's not technical skills we're looking for, it's nice people. We can train people to do anything technical, but we cannot make them nice."[24] At Southwest Airlines, a similar policy prevails. As Herbert Kelleher, the CEO, puts it, "Hiring starts off looking for people with a good attitude—that's what we're looking for—people who enjoy serving other people."[25]

Back to the mammography unit for my IVP. I watched as, in the next 10 minutes, with unfailing patience and courtesy, the receptionist gave directions to 4 patients who had arrived at the wrong place.

The radiology tech escorted me to my exam room, 50 minutes late. The technician, nurse, and radiology resident were pleasant and supportive. No one seemed concerned about the delay. When I commented about late starts, the nurse said, "If you think you're late, wait until they finish the 22 cardiac caths they have scheduled today." The procedure went very smoothly. On my way out, I stopped to compliment the receptionist for her patience and persistently good customer service. She beamed, "You don't know how nice it is to hear that."

If the films had been of poor technical quality, the staff would probably have heard about it. The service aspects were unexamined and lost except for this retelling. Also lost was the concerted effort by many employees to be courteous and helpful. Committed organizations make a point of identifying, recognizing, and celebrating service. This includes, but is not limited to, compensation and promotion systems. A simple thank-you from a person in authority goes a long way toward helping embed service in a culture. How often do these employees get thanked and by whom?

Finally, in this small example, how many delays occurred, how much rework, multiplied how many times, and at what cost? The amount of waste is likely to be staggering.

SERVICE, MEDICAL OUTCOMES, AND COST

Although providers want to provide high-quality service, the subject is not widely discussed unless this month's patient satisfaction numbers drop. Our technical orientation leads us constantly to seek other measurements than the service quality that patients value. Many readers of this journal, having read my vignette, will say, "Interesting, but so what? I care about service and I don't see how this applies." In the vernacular of television, "Where's the beef?" The "beef" for clinicians, beyond pleasing our patients, is improved outcomes, improved clinician satisfaction, and better patient care; for administrators and executives, it is all of the above and efficiency with lower costs.

Outcomes are undoubtedly affected by delays in diagnosis as described in the example. Also, several lines of research have converged on the finding that interactions with patients and their families—properties of care that we call "service"—have remarkably strong effects on clinical outcomes, functional status, and even physiologic measures of health.[26,27] This is a complex subject that will be explored in a subsequent article. Suffice to say, increasing service quality has improved outcomes generally in medical illness[28] and specifically in controlled studies of diabetes and hypertension,[29] asthma,[30] and rheumatoid arthritis.[31] Surgical outcomes show similar effects. Devine,[32] in a meta-analysis of 191 studies, found im-

proved surgical outcomes (fewer complications, shorter hospital stays) associated with service quality interventions based on what patients value. In addition, in this age of physician angst, it has been clearly demonstrated that satisfied patients improve physician satisfaction.[33,34]

The same literature has shown significant reductions in the costs of care when service improves. The dynamics of poor service often involve wasted effort, repetition, and misuse of skilled employees; these same defects raise costs even while they abrade the people in the system.

Waste and redundancy are costly in any organization. American industries find waste unacceptable as they face new, aggressive global competition and look continually for new methods to improve and gain competitive advantage. Competitive pressures are also rising in health care in an unprecedented fashion, and we believe some of these methods[35] will also find a place in our systems of care.

RECOMMENDATIONS

In summary, this IVP occurred in a sick service system. The cure is not simple. Exhorting employees or blaming managed care will not help. Great service, like performance of all types, resides in organizations and the people who work for them. How to do it? The specifics vary, but there are underlying principles that seem consistently present when a Federal Express emerges as superior in package delivery or a Vanguard in the mutual fund industry. We have adapted some of these principles to health care:

- *Define the customers and focus on them.* Using service quality principles, the focus is the patient, not clinicians or institutions.[36]
- *Understand, design, and simplify the processes of care as seen through the eyes of the patient.* A service industry approach would identify and eliminate all steps that do not add value for the patient.[37] Removing wasteful steps has the dual effect of increasing both patient satisfaction and staff satisfaction while reducing cost.
- No matter how effective the processes, it is the people who really count. *Great service quality begins with committed and supported employees.*[13(pp30-33,256-257)] Hiring for attitude is essential. Then leaders must ensure that the organization's allocation of resources and systems of rewards and compensation are in alignment with the service mission. To maintain a service-oriented environment, service-oriented employees must consistently benefit.
- As service-oriented employees benefit, service quality improves because *employee satisfaction mirrors customer satisfaction.*[38] Unhappy, disgruntled employees struggling with inert, service-blind systems produce unhappy, disgruntled customers. Capable, service-oriented employees supported by an environment and infrastructure clearly designed to make them successful produce loyal, happy customers, even advocates and "apostles."[39]
- Employees become the center of action, the listening posts for the organization, and every error becomes a treasure, a chance to do better. When service fails, as it does in the best organizations, *an effective service recovery program*[20(pp148-150)] should exist that provides action on the spot to resolve problems.
- Great service organizations look outward as well as inward. Leadership must forge *dynamic relationships with like-minded, service-oriented partners.*[13(p184)] Not all employees are able to provide high-quality service, nor will all physicians, nurses, other clinicians, suppliers, hospitals, or health plans. This means contractual relationships based not just on technical standards but also on technical and service excellence.
- Properly managed, *service quality will contribute to management of the cost of care.*[13(pp39-53)] Understanding and simplifying the processes of care eliminate waste and thereby lower cost. Experience in other industries suggests those organizations that successfully implement these steps deliver higher value at lower costs while increasing profit margins.
- *Customers buy results, not products or services*[13(pp12-14)]; *patients and payers will do the same.* Following the model of service industries, as patients experience the results they feel are important, patient loyalty and retention are enhanced. Retention stimulates word-of-mouth advertising, leading to related services and referrals, the 3 Rs of service quality.
- *Breakthrough service firms change the way business is done in their industry.*[13(p16)] All potential patients' expectations are changed by this progressive cycle. Other organizations must now compete on service quality. In time, the rules of the game change.
- Finally, to initiate and sustain these changes requires a *consistent environment and dedicated stable infrastructure* in which all the elements required for great service are integrated and reinforced. Industry experience[36,40] and leadership research[41] suggest such a pervasive ethic calls for the *commitment of skilled leadership*[13(pp236-251)] at all levels of the organization. This precept applies as much to the 1-doctor, 2-employee private practice as to the CEO of a 1000-bed hospital.

CONCLUSIONS

We believe physicians and hospitals want to provide high-quality service to patients. The information quoted above and the lack of basic service quality techniques in our industry suggest we can greatly improve. How to start? More rigorous study of service in health care is 1 answer. Second, we can look to experience outside health care. If others have found ways to improve quality, reduce waits, answer questions, preserve dignity, customize experience, assure physical and psychological comfort, and offer choice, we in health care have an obligation to study these methods for their potential value in helping to achieve our main mission: to preserve and restore health.

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