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Health Care: Patient Oriented Perspective and Measure Development

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Abstract

Quality and satisfaction in health care services of extreme significance. The provision of healthcare is one of the most important indicator of the country. It is for this reason every country faces challenge at two levels in the provision of health services. The first challenge pertains to making the health services available down to the lowest denominator of population and the second test pertains to the provision of quality in those services. Delivering quality health care is one of the most common goals of economies across the world. Quality in services is a complex and nebulous construct. And the difficulty is further compounded by its nature of context specificity. It is the lack of its generalizability that requires a bottom up approach to its articulation and apprehension. In this background, the present study seeks to investigate customer oriented perspective to health care services by using critical incident technique. The study sought to uncover how consumers view their experience when they use health services. The customer oriented perspective is essential for any health care organization in order to meet and exceed customer expectations. It serves as the fundamental starting point for competing in a competitive frame of market. The study's relevance stems from the fact that policy governing health has been undergoing a steady change by which the health care is being liberalized for participation by private sector providers and government is also forcing its public health systems to adopt customer centric approach to manage their services.

Keywords: Health Care service experience, health care quality, customer centricity, SERVQUAL, patient satisfaction

JEL Classification: I12

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Introduction

Health is one of the important pillars on which the state of an economy depends. The economic health and health of people are intertwined. British Prime Minister, Benjamin Disraeli once observed, "The health of people is the foundation upon which all their happiness and all

their powers as a state depend". Health at the basic level is primary need for individual's happiness and at a higher level, it is essential for creating productive workforce. It is the fundamental building block for the development of a prosperous society. Poor health has a devastating effect on people and it can push them into unending poverty cycle.

In Indian context, health is one of the top priorities of the constitution. The country has the second largest population in the world but it does not have adequate infrastructure to cater to healthcare needs of the population satisfactorily. The Indian constitution mandates healthcare provision as the primary responsibility of the state. The reality is that India's health care system stands at number 112 out of 190 countries (World Health Report, 2000). This state of affair is laden with both pessimism and optimism depending upon the viewpoint taken. The unserved or underserved presents huge opportunity for ventures to cater to this market. Simultaneously, the healthcare landscape is undergoing a subtle transformation in well to do sections of society as well. With a CAGR (compounded annual growth rate) of 22.9%, health care market of India is estimated to reach US$ 280 billion by 2020. It is estimated that Indian health care sector is going to touch $280 billion during 2015-20 (Healthcare, 2015). This growth is likely to be fuelled by changing life style patterns, increasing incomes and health awareness. The size of the market opportunity apart, its translation into effective business is a difficult task. Notwithstanding whether this market is likely to be provided for by government run institutions or private players, the health care needs to evolve from its present dispensation. A transformation in vision, system and strategy is needed. In order to fill the health gap, the government is gradually moving from state run health care provision to a hybrid model in which private sector is invited to collaborate in this mission through partnerships.

There are some unique aspects of state of health in India (Jayaraman, 2014). These include divide between rural and urban health care, out of pocket expenses to meet health care needs, need to fix primary health care, and underdeveloped medical devices sector. There is an immediate need to attend to health care concerns in the diseases which often assume epidemic proportions like malaria, tuberculosis, diarrhea, malnutrition and infant mortality.

Health care is a service. Like other services, healthcare systems tend to be operations dominated. A service is an act, deed or performance (Berry, 1980; Lovelock, 1983) which is performed by people or people plus machines for the benefit of its recipient and it usually involves interactions between provider and patient. By virtue of its nature, typically services tend to be operations dominated and oriented (Srinivasan, 2012; Lovelock, 1981). This orientation stems from the orientation of people who operate at the helm of affairs. Typically, the services are created and run by technically oriented people. The people responsible for system, equipment, process, job and competency design typically belong to a narrow area of expertise. In health care systems, the operations or activities solely depend upon the expertise of doctors or other staff who come from technical backgrounds like surgery, medicine, diagnostics, and nursing. Services are about application of specialized competencies (Vargo and Lusch, 2004). Secondly, cumulatively these technical people constitute the biggest department in healthcare systems. As a consequence, health care systems tend to be characterized by culture which can be characterized as 'operations mindset'. This mindset which is technically oriented is likely to manifest in day to day functioning of the system. Since it originates from technical personnel, it manifests in goals, roles, authority and relationship structure of the system. One of the direct influences of this is on the articulation and implementation of quality. Quality therefore takes an insider and technically correct view which often fails to incorporate the patient centric perspective.

Marketing or patient centricity has been historically an anathema in services, especially in health care. Services are late to join liberalization and opening up to free competition. The presence of entry barriers has been responsible for demand-supply gap that always worked in favor of service providers. The opening up of health care in India to private sector let alone to participation by foreign health care firms is still intensely debated. The situation of excess demand makes survival easy and does not encourage firms to embrace marketing. The functioning of healthcare institutions in operationally oriented manner often is the cause responsible for patient dissatisfaction (Fancott, 2013). These cause, the systems to be inward oriented rather than market oriented. But provision and practice of health care should be provided in patient centric fashion both as a survival strategy and as ethically correct. Hence, the health organizations require transformation both at the thought and deed level. They need to structure their operations around patient needs and expectations (Baker, 2014).

The developments both at the demand and supply side require health care service providers to be open to the concepts and practices of marketing. Unlike the past, the simple presence of demand is unlikely to translate into successful business. The growth is coupled with globalization and intensification of competition at different tiers of market. Further, the information technology and connectivity has created a power shift by making people informed. The customers now demand more and demand transparency.

The question that must be addressed is how a health care system should be organized. The experience of other sectors informs that an organization must adopt 'outside in' rather than 'inside out' perspective (Levitt, 1960). The business must be approached from the perspective of the taker of its performance who is present at the other end of the spectrum. In this case it is the patient. This transition from operations orientation to marketing oriented mindset requires a change in the way a health service or products is defined, the processes are organized, and priorities are set. Several areas assume importance in this context including marketing segmentation, product development, service delivery process reengineering, service communication, health care quality and post treatment care management. In order to stay in business, the satisfaction is prerequisite. The systems, notwithstanding, they are in health care provision cannot thrive by dispensing dissatisfaction (Pomey et al., 2015). In this background this study aims to explore what constitutes health care experience and seeks to develop a reliable measurement instrument of patient experience in healthcare.

Rationale

The Indian health care sector is on the cusp of a major change. On the policy side the government health has become a national mission which seeks to make public health system fully functional and accountable. Indian health care sector is characterized by multiplicity of systems. The private sector provides services in different forms and practices (Baru, 1998). There are private practitioners, doctor entrepreneurs, for profit small and big firms and small and big not for profit trusts. Both among the governmental and private service providers there is an awakening with respect to greater accountability and quality. The private players like Apollo and Max are subject to greater scrutiny by facility users for prices of their services. The quality of patient care provided by government and non-government entities now does not escape public gaze. The not for profit institutions are not able to hide behind their philanthropic orientation to insulate themselves from quality scrutiny. The customers are now no longer passive receivers of services notwithstanding whether the provider is public or private. Failure to meet customer or patient demands finds manifestations in either legal suits or public debates both of which can inflict monetary and non-monetary damage to systems.

Health is a high involvement issue. The risks and uncertainty involved using health services make it subject to extensive critical examination and analysis. The problem is further compounded by its intangible nature. The intangibility makes it elusive and subject to assessments based on perceptions rather than objective quantification on tangible dimensions. This poses unique challenge both for the provider and receiver. Unlike manufacturing of a physical product, engineering of health services is near impossible. The perception based assessments can potentially create a mismatch between what is delivered and what is perceived to be received. The technical view of excellent service may be at departure from what non-technical patient considers it to be. Hence there is a need for achieving harmonization between the lens that providers and users use to arrive at construction of reality in their minds. The perceived quality acts as an antecedent to satisfaction which is an important determinant of future customer response (Parasuraman et al., 1988). There are many ways of looking at satisfaction but the most widely accepted perspective is based on disconfirmation model which is a function of discrepancy between perception and expectations (Oliver, 1980). The disconfirmation instead of expectations has significant effect on satisfaction (Oliver and Bearden, 1983).

Customer centricity is essential path to succeed in a competitive environment. It requires putting the customer at the center of the organizational universe. Positive marketing outcomes can only be achieved when product performance meets and exceeds customer expectations. One such school in this regard is service quality. Service quality is the discrepancy between expectations and performance on select dimensions (Parasuraman et al., 1988). The service quality is not an end itself. Rather it is a customer response to it. Customer satisfaction is fulfillment response to these discrepancies. Different tools have been suggested and used in the evaluation of customers' expectations concerning service quality. SERVQUAL scale is most extensively used service quality measurement tool. It assesses the expectations and performance gaps as antecedent to satisfaction. But this tool is not a universally applicable tool across all services and all geographical markets. In this background, the present study seeks to explore the concept of patient experience across three different categories of health care institutions. And this study does not begin with the assumption, service experience constitutes of five service dimensions as categorized by earlier SERVQUAL model. Rather it seeks to make a fresh dive into patient experience and explore its constructional aspects in Indian context. The SERVQUAL has been criticized on many counts including the theoretical and operational basis. Particularly the universality of quality dimensions is challenged (Buttle, 1996). Customer satisfaction is an experience based construct. It is customer's appraisal purely based on his or her experience about the extent of fulfillment of expectations (Bruhn. 2003). The health care landscape and patient conditions are uniquely embedded in Indian economic and cultural reality which makes it significantly different from western countries. Further, the knowledge and information about the drivers of customer satisfaction in health services is not fully understood and previous studies offer contradictory conclusions (Rivers and Glover, 2008). This study will contribute to the existing literature related to the service quality, satisfaction and patient experience in healthcare context.

Conceptual Foundation and Hypothesis

As mentioned in the preceding paragraphs, the health sector collectively for a country and individually for a person is very important. The debates and discussions regarding this sector range from national health policy to individual experiences. Health providing entities unlike other industries are subject to greater scrutiny on account of ethics and morality. This element is invoked through the very oath that is taken by physicians. The people in this sector are expected to adhere to certain ethical standards. In other words, participants in provision of health are

ethically expected to give priority to patient interest and thereby provide quality care. This in other words is a method of extracting patient centric performance from health professionals by invoking conscience. On the other hand, the protection to patient vulnerability to unscrupulous practices is ensured by legal mechanism. An array of laws and regulations are enacted to protect the interest of patients who are severally handicapped by information asymmetry and vulnerabilities arising out of poor health. On the whole, from both collective and individual perspective the quality of service and patient experience are critical issues.

The monopoly is anti-consumer. This structure allows the firms in exploitation situation to earn super surpluses. Several studies have explored relationship between competition and health quality, value delivery, cost to customer and satisfaction. The competition is warranted in health care industry because like any other industry it reduces inefficiencies which benefits customers (Fuch, 1988). The competition in health care operates at different tiers of service provision including physicians, primary care centers, nursing homes and big integrated hospitals. The competition is growing and patient expectations are on rise (Coddington et al., 1985; Kumar et al, 1997; Kandampully and Butler, 2001). Patients' comprehension and assessment of the quality of healthcare services has been accorded importance by many authors. It is stated that patients' interaction with the doctors and interference in service delivery process are essential important areas for improving healthcare patient experience (Simmons et al., 1986; Phillips et al., 1986; Lipton et al., 1987; Simmon and Lapham, 1987; Simmons and Phillips, 1992). Two aspects that have critical effect on patient experience are technical and interactional. The technical part refers to the correctness or suitability of service and dexterity with which it is provided. The interaction dimension represents the standard of patient- doctor interactions during the course of service provision.

Quality: Concept Development and Application

Historically, the downing of competition in various American industries in 1970's led to recognition of quality as a concept which was followed by invention of TQM. Prominent contributors to the field include Deming, Juran, Crosby and Ishikawa (Mcglughlin and Kaluzny, 1999; Haigh, 2000; Kruger, 2001; Logothetis, 2003; Mohanty and Lakhe, 2006). Quality is driver of productivity and competitiveness. Deming introduced a paradigm shift in quality thinking from inspection based to building quality (Logothetis, 2003). Building good quality is better than inspecting poor quality. In recognizing the role of top management Juran observed that quality control must be made an integral part of top management function (Kruger, 2001). Quality guru Crosby (1979) proposed the concept of zero defects and laid stress on doing the job right the first time. In the context of health care total quality approach is multidisciplinary in nature because of interdependencies involved between professionals, non-professional staff, information systems, policies and procedures, physical systems and other influences (Berwick, 1991). These interdependencies between different actors, processes and systems render quality articulation, implementation and management difficult phenomena.

Service Quality Measurement

Ever since quality's instrumentality in achieving market related outcomes was recognized it assumed central position in marketing of goods and services. Its role as an important driver of customer satisfaction and loyalty gave impetus to the development of scientific approaches to its articulation and measurement. Quality could not be left to chance. It cannot be accidental achievement in competitive landscape. As mentioned earlier SERVQUAL is most widely used tool (Parsuraman et al., 1988). It measures the discrepancy between expectation and perception of the

service performance on five quality dimensions. It is also widely applied in the health care context. But findings across studies have not produced consistent results.

Babakus and Mangold (1992) found SERVQUAL to be a reliable and valid instrument in the measurement of health care quality, while Bowers et al. (1994) did not find it to so and recommended modification. Bowers et al. (1994) suggested addition of two aspects in the instrument. These relate to patient 'caring' and 'patient outcomes'. The 'caring' dimension relates to 'personal, human involvement' in the health service situation and recognizes the role of emotions and love for patients. The dimension of 'outcomes' relates to 'relief from pain, saving of life, or anger or disappointment with life after medical intervention'.

The satisfaction driving attributes in health care are still not fully defined and it is for this reasons these attributes are not effective in improving service quality (Nelson & Niederberger, 1990). Haywood-Farmer & Stuart (1990) advocated this measure is not appropriate for measuring professional service quality. It does not provide for dimensions like core service, service customization and knowledge of the professional. Brown & Swartz (1989) found professional credibility, competence and communications as important factors important to both doctor and patients in quality assessment. Peyrot et al. (1993) distinguished service aspect into three factors by using factor analysis: staff behavior (friendliness, helpfulness, and explanation), pre-examination comfort (e.g. waiting room comfort, waiting time, forms easy to fill out) and examination comforts (physical comfort and time in examination room). Gabbot & Hogg (1994) suggested six factors for assessing consumer satisfaction using cardinal component analysis with a varimax rotation: range of service (e.g. specialists, facilities for disabled), empathy (e.g. receptionist behavior, besides manner, home visits), physical access (e.g. parking, access by public transport, convenience of appointment times), doctor specific (e.g. age, sex, number of doctors), situational (e.g. waiting room facilities, practice decoration), and responsiveness (time spent with doctor and time spent in waiting room). Drain (2001) mentioned four factors on the basis of research conducted on the satisfaction of patient with GPs, namely, care provider, access to care, office visit and personal issues. Four stable dimensions were suggested by Dean (1999) when he used SERVQUAL to explore service quality dimensions in two dissimilar healthcare settings (medical center maternal and child health center). The four factor anatomy i.e. assurance, tangibles, empathy and reliability/responsiveness (loaded together)-estimated to approximately 86% of the variance in both settings.

Literature on studies in healthcare suggests that perceived service quality is dependent upon the type of service offering. This brings light to the fact that one comprehensive measure cannot be applied to all health settings. Although popular but SERVQUAL does not incorporate aspects that are crucial for healthcare services users. Lanning & O'Connor (1990) in this regard suggested that health care quality improvement efforts must incorporate patient perceptions. It is in this background, this study was undertaken to explore aspects that are critical to patient in judging the health care service and have bearing on their satisfaction. Therefore, instead of adopting an incremental approach by which a measure is adapted and improved, this study sought to explore patient experience with a zero base to apprehend the determinant of patient experience in context specific to India.

Objectives of the Study

Health care sector in India has grown and is poised to grow even further. Growth is a challenging stage and it sets stage for future shakeout which follows once this stage is followed by market maturity. Sooner than later, like other industries patient satisfaction would become critical

determinant of survival in this sector also. The patient centric organization of health care system is rare but it is getting embraced by at least private organized health care providers. The starting point in this regard has to be the customer instead of the provider. It is the customer who should define the business and business should be seen from customer's perspective (Drucker, 1974). Defining patient experience in health care is difficult and elusive. However, appropriateness of processes and result of care are two important concepts in this regard (Lohr et al., 1988).

There is a difference between operationally defined quality and customer defined quality. The mismatch between the two leads to frustrated and dissatisfied patients. Currently, the healthcare is marred by huge number of patient complaints. Thus, in order to compete in this market in future, health care systems need to adopt patient driven quality definition and practices. The relevant question is who articulates what is patient experience in a healthcare system. The problem is that people responsible for taking such decisions are usually insiders bound by their backgrounds and training. The inability to create satisfactory outcomes generally has roots in missing patient oriented perspective.

Research in health care patient experience in India needs to be strengthened (Sivakumar, 2014), studies in health care in India are confined to the application of scales developed in western part of the world (Chakraborty and Majumdar, 2011; Kavitha, 2012; Karekar et al., 2015). Scale specific to Indian context needs to be developed and validated. In this regard, the present study strives to fill this gap and contribute to the literature by developing health care patient experience scale in Indian context. The scale would enable health care providers to assess their services and thereby upgrade by ameliorating on the important patient experience aspects. It is in this background the present study has been undertaken. The specific objectives guiding this study are as follows:

1. To explore how customers of health services view service delivery specifically with intent to uncovering important satisfaction driving aspects.
2. Based on the outcomes of the first objective, development of a valid and reliable measure to assess health care patient experience.

Research Methodology

Measure development instead of adoption or adaptation is an arduous process. In order to establish the construct domain, dimensions isolation and measure development is a multi-stage exercise. In this study we adopted the methodology proposed by Churchill (1979). The method is widely accepted and adopted in various studies (Babakus and Mangold, 1992; Jayanti and Burns, 1998; Sharma and Chahal, 1999; Cegarra-Navarro et al., 2012). Both qualitative and quantitative methods were used in the pursuance of objectives. The study was conducted by surveying patients in hospitals of Delhi and NCR.

Domain Stipulation

At the first stage, extensive review of literature was carried out to understand the articulation and development of healthcare patient experience construct. This involved studying and analyzing all possible studies related to the domain. This was followed by using critical incident technique (CIT) to enable patients reveal their experiences in a healthcare organization. In other words, the patients were asked to write down the episodes that in their opinion were either happy or bad experiences reflecting patients' delight and frustration. CIT has been widely acknowledged as a research technique used for collecting qualitative data. In the field of healthcare, the technique

has been applied in a number of areas such as nursing, medicine and dentistry (Norman et al., 1998; Kemppainen, 2000; FitzGerald, 2008; Schluter, 2008; Yonas, 2013; Scharein and Trendelenburg, 2013; Mulholland, 2015). CIT enables the researcher to get a holistic understanding of the situation. The technique was first delineated by John C. Flanagan in 1954 and was thereafter attributed with the "time sampling studies of recreational activities, controlled observation tests and anecdotal records" (Flanagan, 1954).

Data collected through CIT was later content analyzed to develop categories. The reported patient experiences were studied to glean insights about how patients viewed their experience and what caused them to fell in a particular way. This process led to generation of a long list of factors contributing to patient experience.

Item Identification

A total of 200 patients were approached to describe their experience with health services. Only those respondents were approached whose experience or incident was less than a year old. The incidents so collected were analyzed by coding, categorization and concept development. These incidents were comprehended to uncover aspects significant to patients in their experience with health care systems. The information obtained through patients was juxtaposed with the information contained in the literature. Categorization of healthcare aspects involved multiple iterations. Feedback and opinion of experts was solicited on the tentative categorization of health care items. A comprehensive set of healthcare dimensions each encompassing several healthcare patient experience items was arrived at, and the questionnaire was prepared with seven point Likert scale. This was followed by ensuring face and content validity of the questionnaire. At the preliminary stage, the questionnaire was administered on 50 respondents. On the basis of the feedback received in the initial stage, questionnaire was adjusted for language and meaning. The modified questionnaire was administered to 100 patients. Results obtained were tested for internal consistency of the instrument.

Data Processing and Measure Development

After generation of the final inventory of items, the instrument was administered on 600 patients of public, private and charitable hospitals in Delhi and NCR using non-probability sampling method. Exploratory factor analysis was carried out to derive the underlying factor structure for health service patient experience. The reliability of each of the dimensions was ascertained using Cronbach alpha.

Results and Discussion

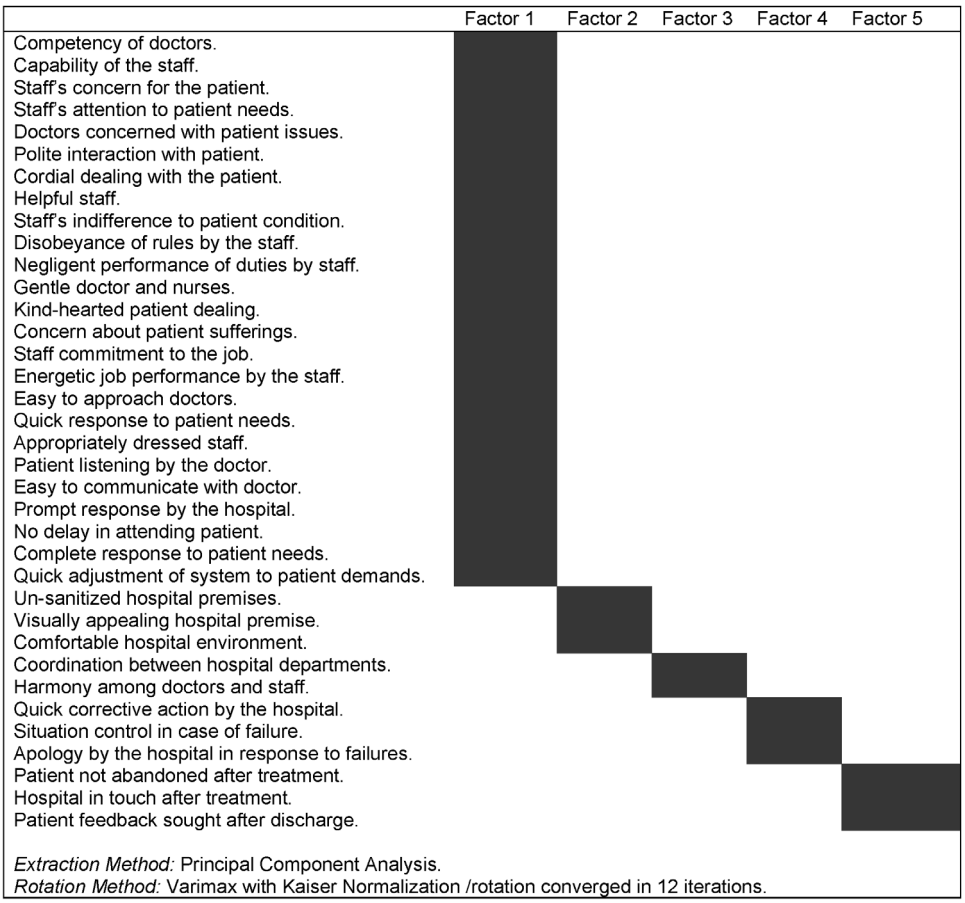
The depth probe interviews revealed various positive and negative experiences of patients concerning health care. These aspects were listed and using qualitative analysis categories encompassing these aspects were arrived at. A careful scrutiny and analysis of the reported experience lead to isolation of aspects that are critical from patient's perspective. The reported incidents were read by two experts in order to identify underlying themes on which experience depend. This process was repeated multiple times in order to ensure that nothing is left out of consideration. This multiple iterative process lead to the identification of ten categories: staff, process, premises management, policies, practices, responsiveness, system, availability, failure to recovery and follow up. The tentative dimensionalisation of the health care aspects was cross examined with the available literature and expert opinion. After determining the content validity of the health care patient experience construct, the data was considered to be fit for next stage

of factor analysis. KMO gave a value of 0.943 and the matrix differed significantly from the identity matrix as per Barlett's test of sphericity. Items with low reliability and low item-to-total correlations were removed from the scale.

Exploratory analysis: Healthcare Patient Experience

Table 1 shows the results of exploratory factor analysis. Using principal components analysis, exploratory factor analysis resulted in a five factor structure defining patient experience in health care (Table 1).

Table 1: Health Care Service Experience Factor Structure Extracted through EFA



These five dimensions depicted satisfactory reliability with an overall reliability estimate of 0.939 for the health care patient experience scale.

Implications

The study discovered that there are five constituent dimensions of health care service experience. Figure 1 depicts the five dimensions that define patient experience in healthcare. These dimensions relate to broader domains of staff, premises management, harmony between functions, corrective actions, and follow up.

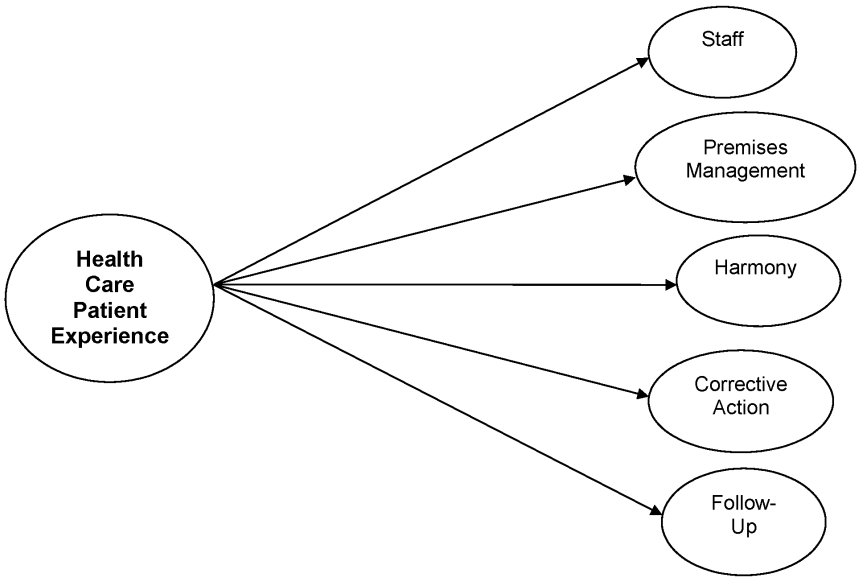


Figure 1: Health Care Patient Experience Dimensions

The most important aspect in patient experience is related to people performance both by expert and subordinate staff. The other studies has also arrived at similar conclusion, staff aspects as central to patient experience (Kabene et al., 2006; Needleman and Hassmiller, 2009; Parand et al., 2014). The conduct and competency of the doctors, nurses and administrative staff has a significant impact on the delivery of health care service. Health is a highly involving and important concern of any individual. Its implications are direct on the quality existence. And most health services continue to be human dependent notwithstanding the involvement of technology. It is for this reason, human aspect lies at the core of it. Majority of critical incidents analyzed in the present study revealed that the behavior of doctors and staff influenced the patient experience to the greatest extent. The importance of this aspect must be understood and in a highly nuanced manner. It is not only the technical core delivery that is important rather how a patient is dealt with in his or her interactions while providing health service that is the lens with which entire experience is sent.

This study found that people attach importance to facility or premises. The premises house the health system where actors perform their act. Since health is sensitive to hygiene it is another benchmark for patients to arrive at the judgments about the quality of care. This finding is in sync with other studies (Carpman and Grant, 1993; Fottler et al., 2000, Lee, 2011). Healthscape components such as ambience, location and decorations contribute significantly to patient satisfaction (Hutton and Ricahrdson, 1995; Lin et al., 2008; Sahoo and Ghosh, 2016). Cleanliness and sanitization of the hospital premises is one of the basics and needs to be met satisfactorily. The physical environment is a critical determinant of the patient-centric health care. The premises must be managed at a multi-senses level. It must be constructed and managed with a view to engage patient senses in such a manner that anxiety is reduced.

Health service is not a singular act of an actor or equipment. It involves multiple actors, processes and systems. From the perspective of patients, two set of actors comprise experts and

subordinate staff. Further their performance depends upon other systems and processes which enable to perform effectively. Therefore any lack of coordination between them affects the health delivery. The effective delivery of health care services is contingent to the cooperation and coordination between the staff members (Fowler et al., 1993; Andrew, 1999). Poor communication in the work environment leads to conflict and affects the productivity of the staff (Ramsay, 2001). Patient treatment is a sequential process and an absence of synchronization can lead to fatal results. Teamwork in healthcare increases the efficiency in service delivery, improves patient satisfaction, induces staff motivation and promotes innovation (Yeatts and Seward, 2000; Borill et al., 2001). Effective interventions in chronic disease management are dependent on competent healthcare teams (Wagner, 2000). Health care organization should strive at delivering seamless patient experience. Medical errors can be hazardous. Medical errors have been identified as the third major cause of death in the US (Makaray and Daniel, 2016). Medication errors are the customary mistakes across the globe affecting health care (Cheragi et al., 2013). Health care mistakes can significantly increase the treatment costs and are a threat to patient safety. Effective control measures can help identify and rectify the errors in the most timely and efficient manner.

Follow up was another aspect found to be an important consideration for patient. Health is high involvement personally significant issue and in many instances recovery is a long drawn process. Therefore patient progress needs to be monitored over a period of time. When a provider concerns with the patient till the time of hospitalization and ceases to pay attention at post operation/service level it becomes major determinant of experience. Several medical treatments needs follow up care involving regular medical check-ups (Rigby et al., 2009). Health care treatment might lead to physical/psychological changes creating challenges for the patient. Follow up care involves guiding the patients in planning for the future and making necessary lifestyle changes. Follow up care can reduce dissonance and help the patient to recover fast. Patients can be given 'Wellness plan' suggesting and assisting patients on physical as well as emotional needs.

Conclusion

Healthcare plays a crucial role in the growth of an individual, society and nation. Although the healthcare sector has expanded, patient experience is still one of the critical issues. Healthcare sector in India needs overhauling. Quality of care lays the foundation for a strong healthcare system. The Indian health industry is making a subtle transition with profound changes at both demand and supply side. The industry is gradually getting competitive at different tiers especially at the organized level. And on the demand side, the information dissemination and greater thrust for transparency is making the patient to demand more. In such a scenario, the old fashioned approach to health care provision is unlikely to work and it is imperative for industry to adopt patient centric approach to care delivery.

It is in this background, the present study was undertaken to explore patient centric perspective to health services. The study sought to uncover critical determinants of patient experience which must become the focal area of management of health providers. Unlike many other studies which used previously developed scales, this study adopted bottom up approach and sought to develop a new measure based on Indian environment. Starting with critical incidents and categorization which was followed by quantitative approach, five factors to patient experience were discovered. These were categorized as staff, premises management, harmony, corrective action and follow-up. Consistent monitoring and assessment would enable reforms in the Indian healthcare sector. The management of health care systems needs to pay attention to these aspects as any failure on these is likely to create upsetting patient experience.

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