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# ESTIMATE THE HEALTH SERVICE QUALITY AT THE PUBLIC HOSPITAL TRIPOLI LIBYA

**Osama Ben Rajab**

Department of Business Administration, Social Sciences Institute, Kastamonu University

**ABSTRACT**: *The aim of the paper was to understand patients with heart failure, with a particular emphasis on their experiences of food and food intake through developing a theoretical model. The study is descriptive and exploratory in nature while using grounded theory approach because the study is inductive in nature, which means that the author wanted to generate theories and models rather than to test hypothesis. The study has used qualitative method and data collection method was interviews of patients with heart failure. To analyse the interviews, interview transcripts were sorted in different categories or patterns, each pattern were coded and then recoded. This means that there were various categories and sub-categories; this helped the authors to see various relations and interactions between categories and/or sub categories. The findings of paper suggest that there are two primary categories, emotions and meaning for food. Emotions such as positive ones could be associated for wellbeing and comfort while negative emotions could be associated with sorrow and burden. Moreover, the patient's experiences of food and eating changed during the course of the disease. Patients with severe heart failure had increased problems with food and ate only for sake of sustenance as a result weight loss was found in those patients. Therefore, as patients with heart failure suffered with sad emotions it reflected in their eating habits, i.e. they lost interest in eating which further resulted in losing weight. These problems are more common in patients above 80 years old however primary health care nurse could help their situation.*

**KEYWORDS**: Tripoli, Hospital Management, Service Quality, Heat Failure, Food Intake

## LITERATURE ON SERVICE QUALITY AT PUBLIC HOSPITAL TRIPOLI LIBYA

### What is Service Quality?

Quality of a service is considered an essential strategy for success and survival in today's competitive environment (Dawkins and Reichheld, 1990). In relation to the service improvement opportunity there are many criteria's that could be used to define a quality service or product. Lehtinen and Lehtinen (1985) "*spoke about the physical, corporate and interactive quality of a service/product*" while Grönroos (1984) referred to "*technical dimension, a functional dimension and the firm's image as a third dimension*" (Chowdhary and Prakash, 2007).

Physical quality argued by Lehtinen and Lehtinen relates to the tangible aspects of the service while interactive quality refers to the interactive nature of services and refers to the two-way flow that occurs "*between the customer and the service provider, or his/her representative, including both automated and animated interactions*" Kang and James (2004). And corporate

quality involves the image accredited to a service provider by its current and potential customers, as well as other stake holders.

Nevertheless Parasuraman *et al*. (1988) published empirical facts from five service industries that recommended that five dimensions more suitably capture the "*perceived service quality construct*". Parasuraman's *et al.* (1988) five dimensions include tangibles, reliability, responsiveness, assurance, and empathy. Each dimension can be examined as follows,

a) *Tangibles*: Physical facilities, equipment and appearance of personnel.

b) *Reliability*: Ability to perform the promised service dependably and accurately.

c) *Responsiveness*: Willingness to help customers and provide prompt service.

d) *Assurance*: Knowledge and courtesy of employees and their ability to inspire trust and confidence.

e) *Empathy*: Caring, individualized attention the firm provides for its customers.

Gronroos (2001) argued that contrary to goods quality, in service quality, "*a need-satisfying equivalent of a product emerges gradually for the customer throughout the consumption process. Hence, a service is a process that leads to an outcome during partly simultaneous production and consumption processes"*. Therefore, the service quality is not same as goods quality, rather the service quality starts before the consumption of service starts, continues during the consumption of the service and sometime ends long time after the consumption finishes. This distinctive feature is due to the intangible nature of services.

Moreover, Stephens and Juran (2004) service quality definition is also interesting, according to them service quality is simply meeting and exceeding customer's expectations from the service. Nevertheless, Scheuing and Edvardsson (1994) argues that although service quality is not a uniform concept and there are great differences, for instance, between professional consultancy, telephone, transport, healthcare and cleaning services, yet despite these differences, services quality and the conditions under which they are delivered have certain generic characteristics in common. For example, the customer often participates in a direct and active way in the production process as co-producer by carrying out parts of the service himself or herself, services are largely intangible and hence not easy for the provider to explain and tricky for the customer to assess before buying, many services are strongly tied to employees and thus inseparable from their performers and lastly, services often "*consist of a market offer composed of various value-bearing elements, sometimes referred to as core service and support services*" (Scheuing and Edvardsson, 1994).

**Quality Measurement Frameworks - Strengths and Weaknesses**

**SERVQUAL**

*The research approach of Zeithaml et al. (1993), i.e. SERVQUAL is inclined on the belief that service quality is measurable, even though due to intangibility it might be more difficult to measure than goods quality (O'Neill et al. (1998). While the SERVQUAL technique has gained a lot of attention for its "conceptualisation of quality measurement issues", it has also attracted criticism, for example, some researchers have debated whether the dimensions of*

*SERVQUAL are constant across industries while others have argued that better wording for some of the scale items (Babakus and Boller, 1992).*

Referring to Buttle (1994), Jabnoun and Chaker (2003) suggests the following advantages of SERVQUAL

- It is accepted as a standard for assessing different dimensions of service quality.
- It has been shown to be valid for a number of service situations.
- It has been demonstrated to be reliable, meaning that different readers interpret the questions similarly.
- The instrument is parsimonious in that it has a limited number of items. This means that customers and employees can fill it out quickly.
- It has a standardized analysis procedure to aid interpretation and results.

*However, from a measurement perspective, SERVQUAL technique has three psychometric problems associated with the use of difference scores: "reliability, discriminant validity and variance restriction problems" (O'Neill et al. (1998). A study by Brown et al. (1993) found evidence that these psychometric problems arise with the use of SERVQUAL; they recommend instead use of non-difference score measures which display better discriminant and nomological validity.*

*However, Zeithaml et al. (1993) responded to SERVQUAL criticisms by arguing that the alleged psychometric deficiencies of the difference-score formulation are less severe than those suggested by critics. However, despite "their argument that the difference scores offer researchers better diagnostics than separate measurement of perceptions and expectations, from a theoretical perspective, there is little evidence to support the relevance of the expectations-performance gap as the basis for measuring service quality" (O'Neill et al. (1998).*

**SERVPERF**

*According to Cronin and Taylor (1992), SERVPERF is a better predictor and technique to measure service quality than SERVQUAL. For example, Jain and Gupta (2004) found that SERVPERF was more strongly correlated to overall service quality than SERVQUAL. But on the other hand, Quester and Romaniuk (1997) reported that SERVPERF does not exhibit a stronger relationship with overall service quality than SERVQUAL.*

*The distinctive characteristic of SERVPERF is that it uses only performance data (unlike SERVQUAL which directly measures both expectations and performance perceptions) because it supposes that respondents offer their ratings by automatically comparing performance perceptions with performance expectations (*Carrillat, *et al., 2007). Thus, SERVPERF assumes that directly measuring performance expectations is unnecessary.*

*However, Abdullah (2006) argues that whilst SERVPERF's impact in the service quality domain is undeniable, SERVPERF being a generic measure of service quality may not be a totally adequate instrument by which to assess the perceived quality in specific service sectors, such as, education or health sectors. On the other hand, SERVPERF (performance-*

*only) results in more reliable estimations, greater convergent and discriminant validity, greater explained variance, and consequently less bias than the SERVQUAL scales (*Llusar and Zornoza, 2000).

**What is the Key Quality Management Frameworks used Within Health Services**

*The department of health's website www.dh.gov.uk (2009a) states that "Clinical governance is the system through which health services organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care". Similarly, Donaldson and Gray (1998) too has described clinical governance as a "framework through which health services organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish" (*Nicholls *et al.*, 2000). Clinical governance is rooted at the core of the UK government's blueprint for quality assurance at a local level (Miles *et al.*, 2001) as a mechanism by which organizations ensure a comprehensive program of quality improvement and have strong arrangements for identifying and remedying risks and poor performance (Walsh *et al.*, 2000).

*The term clinical governance was first used by the World Health Organisation (WHO) in 1983 to summarize the conditions of high-quality health care on four important dimensions: "professional performance, resource allocation, risk management and patient satisfaction" (Penny, 2000). In reaction to frequent system failures resulting in a series of unpleasant incidents, the Labour Government introduced clinical governance in 1997 in* health services *to encourage an integrated approach to reduce risk and develop the quality of clinical care (Gray, 2001).*

*However,* McSherry et al., (2002 p24) argues that clinical governance is prone to several criticism, such as, it can be time consuming, cost incurring, could be seen as a policing mechanism, potential to reduce innovation, openness to criticism, it is a long-term strategy and potential of increased litigation cost. McSherry et al. (2002) further criticises that clinical governance places more demand and unrealistic expectations from busy people and ground level health services professionals could lack in knowledge to execute clinical governance effectively.

*But on the other hand, according to* Lewis *et al.*, (2002) *"... rather than being a cumbersome activity that must be added to the endless list of tasks health professionals are expected to undertake, it (clinical governance) provides the opportunity for staff to acknowledge that a lot of what they already do contributes to the clinical governance agenda, bringing together work as part of a common aim to improve the quality of patient care." Therefore, from this perspective clinical governance takes a wholesome approach to deliver quality service. Nonetheless, t*he introduction of clinical governance, as a framework through which health services Trusts are accountable for continuously improving and safeguarding high standards, has raised a challenge for management teams across the country to deliver quality service (Lewis *et al.*, 2002, referring to DoH, 1998).

*Theoretically clinical governance is different from broad uses in that it relates particularly to continuous quality improvement and is now a policy instrument for modernising health care (Gray, 2001). Som (2004) illustrates this further by arguing that the structure of clinical governance recognizes the clinical complexities and tries to overcome some of the obstacles*

*and challenges by encouraging an integrated and organisation-wide approach towards constant quality improvement. The process of clinical governance also involves "multi-disciplinary teamwork, partnerships and co-operative working practices that will have far reaching implications for clinical relationships, the behaviour of medical professionals and ultimately the delivery of care" (Som, 2004).*

**Potential Research Questions**

A. Is '*Clinical Governance' an appropriate quality management method for* at public hospital Tripoli Libya Trust?

B. Is there any extent to which '*Clinical Governance' can influence* at public hospital Tripoli Libya to deliver better service quality?

C. What are the factors that mediate between '*Clinical Governance' and Service Quality at* public hospital Tripoli Libya?

**Reflection Report on Qualitative Data Collection**

**Results**

In my qualitative research, I found interesting insights and explored new underlying reasons in my qualitative research on my class mates. Most of the students I interviewed explained that they enjoyed smoking when they were nervous or stressed however none could exactly say what feeling they enjoyed in smoking. The participants explained and stressed on the fact that, smoking is more of a habit than necessity, but the habit of smoking is a necessity. This finding was interesting because the participants didn't think smoking is essential but to practice the habit of smoking is more important for them.

The participants revealed mainly two reasons why they started smoking, first was the celebrity effect and second was loneliness. Most of the participants who said that they started smoking because they wanted to be like their idol celebrity were in their 30's while students who said gave the reason of loneliness seemed to me in their 20's.

Most of the participants agreed that they would do their best to avoid going to places where they could face problems due to prohibition of smoking. However, no one could give an exact answer of what they might do when they are in situations in which you can't smoke but agreed that they would do their best to avoid going to such places. Participants also suggested that the most difficult thing would be to keep their patience and concentrate if they cannot smoke.

All participants except one said that they do worry about the health risks of smoking, those who did not excepted gave reasons that they don't think there is enough evidence to suggest that there are health risks due to smoking. One of the two who didn't except, explained that his grandfather lived for 90 years, even though he spoke raw tobacco since he was 15.

Most of the participants said they don't mind the ban on smoking in public places as long as there is a separate designated place for them to smoke, however if there is no place to smoke than many participants suggested that they would consider it as discrimination against those who smoke.

I my study the participants revealed that they would least prefer to smoke in places, such as, children's room or where children are around, GP and hospitals, schools, religious places, parks and public transportation. All the participants gave moral responsibility reasons to justify why they would least prefer to smoke at those places. The participants said they smoking ban has affected their living standard in the society because it seems to them that most of the non-smokers look at smokers as "criminals". The word 'criminal' appeared often in this study in context to the questions "Has the smoking ban affected your social life". However, the participants clarified that smoking ban has in no ways changed their smoking habits, as one of them says "where there is will there is a way".

None of the participants in our study said they every tried to quit smoking, although some of the participants has been persuaded or they thought about it. The participants justified this by saying that they were not enough motivated to quit smoking. But few of the participants agreed that they don't mind looking into new ideas which will motivate them to quit smoking.

**Process**

The participants of this study were included in this research using judgemental sampling, because it was less expensive and less time consuming and yet convenient however the findings drawn in my study could be difficult to generalize and be subjective (Malhotra, 2004 p331). The participants were interviewed in the cafeteria of the university and I made sure that the interview was not overheard or could be interrupted by anyone, this was to reduce biased opinions from the participants (being aware of the fact that someone else is hearing them and what they might think of them) (Malhotra, 2004 p147-148).

The major problem that I faced during my interview was the fact that interviewees drifted often from the research question, although some out of context answers were useful but rest were generally not related to the research aim and hence not useful. One of the participants started talking about his grandfather and his livelihood, which was not at all related to the research topic, which is smoking habits. Bringing back them back to the research topic/question was not easy.

Nonetheless I found qualitative method very useful in finding information's that I didn't think of before, it helped me to explore not only new ideas and concepts but also underlying reasons for them. I think this research method will be very useful when there is relatively information on the research topic and the purpose if not to test hypothesis. But on the other hand, this research method might be expensive and time consuming when conducted on a larger population size, and if the sample size is small it might be difficult to generalize the findings. In spite of these shortcomings, qualitative research method (interviews) can be very useful.

**A report of Quantitative Data Collection**

I have designed a short questionnaire to examine whether smoking is facilitated by addiction, by stress, or by both. Questionnaire is a 'quantitative method' that gives statistical and numerical presentation of data, which helps in better rationalising the relationship between primary data and secondary data, and between more than one variable in primary data (Hague; 2002 p48). Since quantitative research methods involve vast number of sample elements or respondents, the results can be relatively a better representation of the entire

research population (Dillon, Madden and Firtle; 1990) as long as there is high correlation and less variability. Moreover, it also helps in testing hypothesis or hunches (Parasuraman, Grewal and Krishnan; 2004 p195-196).

However, quantitative research often results in producing "banal and trivial" findings of little consequences due to restriction on and the controlling of variables, hence (Burns, 2007, p10) states that quantitative research produces "synthetic puppet show" or an artificial situation rather than rich dynamic information. One the other hand, quantitative method also helps in greater understanding of concept or clarifies a problem rather than providing precise measurement or quantification as it is descriptive in nature emphasising on words rather than numbers (Zikmund, 2003 p87). The questionnaire method has helped us to elaborate statistical and numerical representation of the findings.

In my quantitative research I have found that this method is cheaper and relatively easier than qualitative method to test a hypothesis, as at relatively less cost and time a wide range of population can be included to test hypothesis. Although in context to my research it might not be correct to say that quantitative research has helped us to explore new findings, rather it has helped to confirm or reject the theories. For example, in my quantitative study I have found that the age group 25 to 34 smokes more (i.e. more than 12 cigarettes per day) than rest of the groups, however there wasn't any scope to find out any underlying reason, which was possible in qualitative research.

In spite of the shortcoming this method has a benefit that is to confirm or reject a hypothesis on a wider population at a cheaper cost and relatively less time. Moreover, statistical diagrams, such as, bar diagrams, pie charts etc., can help readers to understand the findings better. If my dissertation is to confirm or reject any hypothesis, I will use this method, however to generate hypothesis and explore underlying reasons I will prefer to use qualitative method.

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